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Implementation of an Advance Care Planning Protocol to Increase Advance Directive Completion Rates

Christine Engle
Valparaiso University

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**IMPLEMENTATION OF AN ADVANCE CARE PLANNING PROTOCOL TO
INCREASE ADVANCE DIRECTIVE COMPLETION RATES**

by

CHRISTINE ENGLE, BSN, RN

EVIDENCE-BASED PRACTICE PROJECT REPORT

Submitted to the College of Nursing and Health Professions

of Valparaiso University,

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ABSTRACT

Advanced directives (AD) allow an individual to retain autonomy in end-of-life decisions and can prevent unnecessary costs and treatments associated with aggressive life-prolonging measures. As of 2017, only an estimated 36.7% of the United States adult population had a form of advance directive documented (Yadav et al., 2017). The purpose of this evidence-based project was to determine if implementation of an advanced care planning (ACP) protocol would increase ACP discussions, AD completion, and result in a modification in stage of change or behavior. The Transtheoretical Model (TTM) and Stetler Model of evidence-based practice were used as the framework to guide project implementation at a non-profit clinic in Northwest Indiana. An ACP protocol was implemented based on an extensive review of the literature on adult patients 50 years and older who presented for wellness and annual exams. Providers and applicable staff were educated on their role in implementing the protocol. Over a 12-week period, qualified patients received an AD information folder when brought back to the exam room to review prior to seeing the provider. Nursing staff documented demographic information, obtained consent for follow-up, and placed a yellow algorithm worksheet at the providers' computer desk to signal that ACP was to take place during the visit. Providers would then initiate ACP discussion by following the six question algorithm on ADs and quality versus quantity of life. Pre-intervention patient data and AD completion rates were collected by the facilities data analyst. Post-intervention data was collected by providers within the protocol worksheet and by the project leader upon follow-up phone calls. Data was found to be significant for an alpha of 0.05 when attempting to detect a significant degree of change in TTM behavior from pre to post of both ADs ($p = .000$) and quality versus quantity of life ($p = .000$). Providers engaged in ACP at a rate of 46%. ACP and AD completion rates increased from baseline values, with 4% of individuals creating and documenting an AD at the initial visit, and 45% of participants creating an AD following the ACP discussion.

Keywords: advance directive, advance care planning, office, primary care, outpatient

CHAPTER 1

INTRODUCTION

While many healthcare providers and individuals consider advance care planning (ACP) to be of high importance, gaps remain for implementing discussions (Arnett et al., 2017). Within everyday practice, patients often do not discuss end-of-life wishes with their family or healthcare providers before a critical illness or traumatic event occurs. Even though there is wide spread agreement about the necessity and importance of ACP discussions and advance directive (AD) completion, conversations do not occur regularly (Arnett et al., 2017). Commonly found barriers to these discussions include a lack of time at appointments, limited training, and lack of system support. A large number of patients may undergo futile or inappropriate interventions at the end-of-life because they did not have the opportunity to discuss or document their wishes (Scott, Mitchell, Raymond, & Daly, 2013). Not participating in ACP prior to a health crisis has the potential for not only increased financial costs to the individual or family from unwanted treatments, but also increased system expenses. Expenses may include an increase in utilization of intensive and invasive interventions that were futile, unnecessary, and undesired, decreased autonomy and quality of life, decreased patient and family satisfaction with end-of-life care, decision-making burden and increased levels of stress and anxiety for family members involved, and increased health care professional moral distress (Ahluwalia et al., 2015; Kermel-Schiffman & Werner, 2017). ACP is the necessary process of communicating wishes regarding end-of-life care and future health decisions with healthcare providers and family members and other significant persons (Scott et al., 2013). General practitioners, because of their long-term relationship and established trust with many patients, are well-positioned to encourage and engage patients in ACP. Despite potential cost savings and other reported benefits associated with ACP, AD discussion and completion rates remain low, with less than one third of the general U.S. population having drafted an AD and fewer than 50% of those with terminal

illnesses having an AD on record (De Vleminick et al., 2013). ADs help to guide health care decisions in times when a person is unable to make such decisions on their own. These directives can include use of a durable power of attorney or healthcare proxy and a living will (Mayo Clinic, 2014). The National Institute for Aging states that it is important to begin ACP and AD discussion before acute, life-limiting illness and to discuss decisions or any questions with primary healthcare providers in order for an individual to retain autonomy and avoid any unwanted treatments or interventions (NIA, 2018).

Evidence-based practice (EBP) is widely recognized as a leading aspect of delivering top quality healthcare while ensuring the best outcomes (Melnik & Fineout-Overholt, 2015). EBP includes external evidence, such as research and clinical expertise, while also incorporating patient preferences and values (Melnik & Fineout-Overholt, 2015). The incorporation of EBP into practice has resulted in improvements in population health, reduced healthcare expenditures, and enhanced care. Despite the proven impact of EBP practice on outcomes, incorporation into daily practice is not consistent (Melnik & Fineout-Overholt, 2015). Without the use of EBP, which evolves on a continual basis, practices become outdated which affects the care of the patients and impacts outcomes (Melnik & Fineout-Overholt, 2015). With consistent use of old practices, or traditional practice, effective problem solving is limited and individual needs and preferences are not considered (Schmidt & Brown, 2015). Strong evidence is necessary to ensure feasibility and support practice change (Melnik and Fineout-Overholt, 2015). Barriers need to be overcome within practice to implement EBP and make it the gold standard of practice. Baseline EBP knowledge must be assessed within an organization and clinicians must become the change agents and facilitators for the implementation of EBP, as it is essential to practice (Melnik & Fineout-Overholt, 2015). Providers are the practice change agents that are necessary to implement the EBP that is ACP with their patients to provide the high quality care that their patients deserve.

Background

The Patient Self-Determination Act (PSDA) of 1990 required hospitals, nursing homes, and other healthcare facilities to provide information to patients about ADs and keep record of them for future use (Spoelhof & Elliott, 2012). Historically, it was found that Americans lacked the knowledge and general awareness of ADs. Despite this they reported interest in their use, with 87% of a surveyed group stating they would approve of their healthcare provider asking them to complete an AD (Hunsaker & Mann, 2013). Of those surveyed, 68% also responded that they had not put an AD in place because the option had not been made available to them. Prior to the implementation of the PSDA, it was estimated that between 4% and 20% of Americans had an AD in place (Hunsaker & Mann, 2013). While a major goal of the PSDA was to educate individuals on the importance of autonomous decisions-making, the overreaching intent was to address the high cost of health care at the end-of-life. Prior to the implementation of the PSDA, 15-20% of the country's hospital budget and 1% of the gross national product was attributed to costs of life-sustaining and life-saving measures (Hunsaker & Munn, 2013). In the past, default treatment was to sustain life at all costs, despite individuals stated preferences to forgo life-sustaining treatment with terminal illness or when recovery is unlikely. In a survey of 405 individuals conducted prior to implementation of the PSDA, 93% stated that they would rather refuse life-sustaining treatments if recovery seemed unlikely (Hunsaker & Munn, 2013). In order to reinforce an individual's right to autonomy in their end-of-life care and to contain health care costs, the PSDA mandated that any healthcare facility serving Medicaid or Medicare patients follow a set of seven statements. These statements include: (1) inquiry of the existence of the presence of a pre-existing AD, (2) providing written information on the right to accept or refuse medical treatment, (3) giving the option to complete an AD, (4) documenting all ADs in medical records, (5) educating the healthcare team, patients, and community on ADs, (6) preventing discrimination of care for or against patients who already have an AD, and (7) establishing and communicating policies on ADs with staff and patients (Miller, 2017).

While the basic premise of the PSDA is obvious, the implementation of these standards within a facility requires a great deal of planning as well as a multidisciplinary team working together to ensure that a patient's rights are honored (Parkman, 1997). The Joint Commission (TJC) has also set requirements regarding ACP and ADs (Patel, Sinuff, & Cook, 2004). TJC found it necessary to weigh in on the importance of ACP and AD documentation as the accreditation body felt end-of-life care and patient safety were not mutually exclusive. TJC (2015) states end-of-life care has emerged as a patient safety issue due to the high intensity of care that is associated with increased hospitalizations, readmissions, and intensive care unit length of stay (TJC, 2015). According to TJC (2015), older adult patients with chronic illness should be presented choices in determining how they would prefer their lives to end, some may opt for a "good death," whereby burdensome pain, symptoms, and technology are diverted.

Currently all 50 states have some form of legislation regarding ADs as well as clear delineations of who can make decisions for those that are incapacitated (Miller, 2017). Specific state laws can decide what AD documentation is legal within that state or who can sign or witness such documents to legalize them. The State of Indiana recognizes eight separate types of ADs. These directives include: (a) talking directly to your physician and family, (b) organ and tissue donation, (c) a healthcare representative, (d) living will declaration or life-prolonging procedures declaration, (e) psychiatric ADs, out-of-hospital Do Not Resuscitate declaration and order, (f) physician orders for scope of treatment (POST), and (g) power of attorney (ISDH, 2013).

Organ and tissue donation allows for clear communication of a patient's wishes regarding organ and tissue donation after death. The organ and tissue directive is one in which the State allows for clear communication of a patient's wishes for organ and tissue donation at the time of death. This communication can be included on the patient's driver's license or in a living will or other AD document. A healthcare representative is defined as a chosen person who can make healthcare decisions and receive your health information for you when you are unable

(ISDH, 2013). The State also dictates that the directive be in writing and signed by the individual as well as another, non-familial adult witness. A living will is a State document that depicts an individual's intended wishes regarding medical treatment of an individual in the event that one becomes terminally ill or unable to communicate. This AD often includes specific instructions regarding the initiation and continuation of artificial nutrition, blood transfusions, cardiopulmonary resuscitation (CPR), or tracheal intubation and mechanical ventilation (ISDH, 2013). A living will can consist of a living will declaration, which informs providers and family regarding directives for life-prolonging treatment; whereas a life-prolonging procedures declaration provides directive on the use of life-prolonging medical treatments (ISDH, 2013). A State psychiatric AD expresses preferences and consent for treatment measures for a specific diagnosis, as long as the individual has legal capacity to do so. An out of hospital do not resuscitate (DNR) declaration and order states that an individual does not want CPR in the event they cardiac or respiratory arrest outside of a hospital facility. A POST is a direct physician order for persons with: (1) an advanced chronic progressive illness, (2) advanced chronic progressive frailty, (3) condition caused by injury, disease, or illness to which there may be no recovery and death will occur from the condition within a short period of time without life-prolonging measures, and (4) medical conditions that if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful (ISDH, 2013). A power of attorney, or durable power of attorney, grants a designated alternate the ability to make decisions on behalf of the individual should they become incapacitated to make decisions for themselves. This defined individual may be chosen to cover financial matters or health care matters, or both. The individual has the ability to modify or cancel any of these directives at any time as long as the individual is of sound mind (ISDH, 2013).

ACP and AD are not routinely addressed within the family practice setting, even though studies have shown that patients may prefer initiation of ACP and AD discussion within the outpatient setting with their primary care providers versus during times of acute illness (Sullivan,

Mailo, Angeles, & Agarwal, 2015). This may be in part related to the importance placed on the relationship that is built between the provider and patient in the primary care setting (Sullivan et al., 2015). Although ACP in primary care has been identified as a preferred setting for conversation, as well as a patient satisfier, barriers have been identified hindering its implementation. Barriers that have been identified by providers include: (a) lack of time during scheduled appointments, (b) lack of reimbursement, (c) perception that patients do not find them important or necessary, (d) belief that most patients will be unable to understand difficult terminology, (e) discomfort with the topic, or (f) assumption that the patient should initiate the conversation (Howard et al., 2018; Puente et al., 2013; Spoelhof & Elliott, 2012). Patient identified barriers to ACP conversation include: (a) belief that the provider should initiate the conversation, (b) thoughts that ACP and ADs are unnecessary or unimportant, (c) belief that they are too young for ACP, (d) lack of knowledge about ADs, and (e) discomfort with the topic. Collins, Horton, and Worster (2016) performed a chart review of a panel of 1,074 primary care patients, of which only 68 (6%) had documented ACP, 41% of which were 65 years and greater. Only 25% of those 68 patients in the study where ACP was documented, then had established written advanced directives. In another study by O'Sullivan et al. (2015), only 43.8% of the surveyed population had previously discussed ADs, and only 4.3% of those discussions were with a general family physician. These statistics bring to light the low number of ACP discussions that are currently occurring within the primary care setting. Initiation of ACP discussion in the primary care setting is increasingly important as research suggests that ACP will aid in making more patient-centered decisions, increase autonomy and control for patients while they still have the capacity to do so, and possibly relieve the burden on loved ones in times of crisis or emergency (Ernecoff, Keane, & Albert, 2016). Those who engage in advanced planning of their healthcare are also more likely to receive care that is aligned with their goals and wishes for end-of-life care (Howard et al., 2018). A study by Yadav et al. (2017), stated that only around 36.7% of those living within the United States had completed any type of AD, with

32.7% of healthy adults completing some type of AD, which depicts the low number of adults who currently have an AD in place and brings to light the priority that is needed to increase completion rates and make it a national priority at any stage in life. AD planning and documentation in the primary care setting is identified as being critical and necessary by such groups as the American Academy of Family Physicians (AAFP). Due to this identified crisis the Centers for Medicare and Medicaid (CMS) have created a process by which providers can be reimbursed for ACP through Current Procedural Terminology (CPT) coding (Department of Health and Human Services, 2016; American Academy of Family Physicians, 2018).

Statement of the Problem

Within the target organization for this EBP project it was identified that there was formal protocol for evaluating patients ADs or process for implementing discussion on ACP at time of office visit. Identified issues included a lack of (a) a formal protocol for discussion or implementation of ACP, (b) absence of readily available information or education available on ACP or AD within the target organization for patients or providers, and (c) lack of a process for the documentation of patients ADs within the charting. Prior to the implementation of this EBP project, ACP and AD discussion only occurred if the patient initiated the topic, and ADs were only reviewed and documented if the patient voluntarily reported patient they had one. The identified problem was thoroughly discussed with the site staff and the office manager, and a need for change in ACP practice was identified.

Barriers to implementation of ACP in this practice setting were identified and closely mirrored barriers reported throughout the literature. These barriers impede the discussion and implementation of ACP and ADs in the primary care setting. Barriers to discussion at the clinical site included a lack of time for discussions, lack of available educational materials for ACP discussion and AD documentation, and lack of a formal knowledge on who and where documentation for ADs should occur. When providers were asked where AD information was kept within the office, replies included "I honestly could not tell you," and "I don't actually think

we have anything around.” Prior to the identification of this problem, the target site had no protocol for ACP or AD implantation, except to inquire of the existence of an AD at the onset of their appointment with no follow-up question regardless of the patients response. Providers stated, “ I don’t think anyone has ever even checked yes to the AD question in the EHR,” and “If the patient doesn’t know what an AD is when I ask about them at intake, we just move on and there is really no further discussion on the topic.” It was identified that the target setting had a single designated area in the EHR for documenting the existence of an AD, however this information is only available to the local affiliate clinical staff and not to local hospitals or acute care centers. Providers stated, “I’ve never actually even used the AD section of the EHR, because no one ever talks about it during the visits.” Office management even stated that “There really is no protocol or method to our ACP in the office at this point, although it is something we have looked into in the past to enhance with our providers.”

As stated by Melnyk & Fineout-Overholt (2015), consistent use of EBP is because it is what will lead us to the highest quality of care and the best patient outcomes. This EBP project was developed to provide a resolution to barriers that may impede the discussion of ACP and the occurrence of ADs in the primary care setting. Moving through these barriers will subsequently increase the patient quality of care through knowledge, understanding, and autonomy in their healthcare choices, bringing about the best patient outcomes. One would then suspect that care would be more patient-centered. Accurate communication and documentation of ACP will result in more appropriate treatment decisions and will ultimately improve autonomy and quality of life.

Data from the Literature Supporting Need for the Project

There is a significant amount of data found throughout the literature that supports the importance and need for this EBP project topic. It is apparent that patients find discussions with their primary health providers beneficial and helpful when they include ACP and AD information (Spoelhof & Elliott, 2012; De Vleminck et al., 2013). Since patients have the right to dictate and

make their own healthcare decisions, the conversation of ADs within the office setting, prior to illness or trauma, is important and necessary. There are a number of barriers to ACP discussions and AD planning within the office setting when a patient is not yet at end-of life, but the literature discusses many strategies to work through these barriers and facilitate the discussions between providers and patients.

According to Malcomson and Bisbee (2009), in many instances education or information on ADs is not given until an acute hospitalization, when anxiety and illness can deter their completion. Experts state that primary care is an ideal setting to address AD beliefs and healthcare wishes while an individual still has the capacity to do so, as any individual may become incapable to make such decisions at any given time without warning (Malcomson & Bisbee, 2009). During a period of relative wellness, a patient is more likely to be open and understanding of the terms of ACP and ADs, facilitating a greater ability to deliver care that is consistent with their wishes. Malcomson and Bisbee (2009) discuss the perspective that patients are willing to and want to discuss ACP and ADs, but feel that their families, friends, and most importantly, their providers, view them as too young or too healthy to bring up the topic at appointments. Otte et al. (2016) also discussed how drafting or working on an AD can be a time-consuming process, which is a huge barrier if the practitioner is not comfortable or well-educated on the topic, or if the patient has no previous knowledge of ADs. Even though ACP is shown to improve patient satisfaction with care, and reduce future treatments inconsistent with the patient's wishes; very few practices implement ACP with patients who are not critically ill (Howard et al., 2018).

Spoelhof and Elliott (2012) state that there are many interventions available to help further implement ACP discussions within primary care, such as clarifying vague terms to patients and providing resources. They also identify that a main barrier to ACP is the patients lack of knowledge and the patients desire that the provider initiates the discussion. Other barriers include providers lack of time and the absence of reimbursement, as well as provider

discomfort with bringing up the issue. The process of ACP begins with the discussion of AD options, from that discussion the process then leads to the formulation of patient preferences, and finally the documentation of the AD for the patient, family, and healthcare team (Patel, Sinuff, & Cook, 2004). It is often suggested that within the outpatient or primary care setting, a combination of written education materials and repeated clinical discussions between the patient, provider, and any family designee, may lead to a higher number of AD completions and patient satisfaction with care (Patel, Sinuff, & Cook, 2014; Tamayo-Velazquez et al., 2010).

Data from the Clinical Agency Supporting Need for the Project

The target organization for this project was a healthcare facility that includes primary care providers, as well as specialty practice providers including pediatrics and obstetrics and gynecology. Office X resides in Northwest Indiana and is not part of a larger health care system. They are a free-standing facility that is owned by an organization in the region. Office X resides in an urban community which is comprised of 49.4% males and 50.6% females and has a median resident age of 38.8 years old and median household income of \$74,123. (City-data, 2018). White alone comprises 86.2% of the population, with 7.2% Hispanic, 3.2% Asian, and 1.3% black (City-data, 2018). Of the population aged 25 years and older, 92.3% have a high school or higher degree, and 28.6% have a bachelor's degree or higher (City-data, 2018).

The average age of patients seen within the office by the primary care practitioners was 45 years of age, with a majority of patients being male. The providers within the primary care practice entity of this facility consisted of two family nurse practitioners, one full-time and the other part-time. Both practitioners served patients of all ages throughout the life-span, but a large majority of the population of patients seen were adults. The children were typically seen instead by the pediatric providers within the facility. The average daily patients seen by each provider ranged from day to day and was anywhere from 12 to 20 patients, with a mean of 26 patients per day. Both providers in primary care saw a variety of visit types and different visit times were assigned to each visit type. An acute issue, such as headache or fever, or chronic

patient visit, such as medication refills or blood pressure check, were usually allotted 15 to 30 minutes, while wellness checks or physicals were given 30 to 45 minutes in duration per visit. Prior to evaluating for and implementing this project into Office X, there was no formal ACP or AD protocol in place, and no formal education or forms for practitioners to give to patients or review with them at visits. There was also no statistical information available about ACP and AD use or completion within the office, as patients were only asked about whether or not they had ADs at the beginning of visits, with no further action dependent on the answer given.

A meeting with the project advising practitioner within the office identified that there existed a lack of ACP and AD documentation within the office. It was agreed that an improvement was needed in the practices within the office regarding ACP and AD implementation for the patients served. Barriers that were identified for ACP and AD discussion within the office were identified as: (1) a lack of time, (2) lack of materials and education for providers to feel comfortable bringing up the subject with patients, (3) lack of a protocol to help establish who would benefit from the discussion and to help easily fit the discussion into scheduled visits, and (4) lack of ability to gain access to patients ADs if they are filled out elsewhere. The project advisor stated “I can’t believe that we have absolutely no AD information in our office. I would have to look it up online and print anything out if a patient needed information.” With these described barriers, it was established that a protocol needed to be put in place that would (1) fit within the office schedule and routine without taking any additional time from patient visits, (2) would give providers the information they need to initiate ACP and AD conversations with patients who would benefit (3) was quick and easy to use, and (4) would support the patient’s autonomy for end-of-life wishes.

Purpose of the Evidence-Based Practice Project

The purpose of this EBP project was to increase ACP discussion in an effort to increase AD completion in this practice. This was to be accomplished with a standardized protocol, educational material for providers and patients, and increasing support providers had in regards

to initiating ACP and AD discussions. In addition to the protocol, there would be an increase in the amount of patient information and education the providers have available for use in ACP and AD discussions, and also an increase the number of ADs filled out or collected from patients during wellness visits. Additionally, it was deemed important to continually evaluate whether a patient had previous recorded ADs, and if any changes were necessary to be made. An additional purpose of the EBP project was to evaluate the ease and effectiveness of the formulated AD protocol within the office setting to encourage provider compliance to its use.

Compelling Clinical Question

Review of literature and the examination of current practices within this office setting identified that within this primary care setting there were many gaps in the facilitation of ACP and AD completion. These gaps included lack of patient education and overall knowledge on their healthcare choices and the lack of engagement in ACP discussion with their primary care providers. Provider-based barriers also existed in initiating discussions of ACP or ADs with those patients not chronically ill or near end-of-life. These included: a lack of time, lack of materials available for education, and lack of a protocol. With increased discussion and exposure to ADs through ACP, patients will have the opportunity to bring up concerns or questions about ACP and specific ADs with the ultimate end goal of completing an AD that depicts their healthcare wishes. Ultimately, patients will have increased autonomy, a decrease in administration of unwanted treatments and the costs that are associated with them, and an overall improved quality of life.

PICOT Question

According to Melnyk and Fineout-Overholt (2015), the first step of EBP is the formulation of a PICOT clinical question in order to then collect the most relevant and strongest evidence. A PICOT question will identify the patient population, intervention or issue of interest, a comparison intervention or group, an outcome, and a time frame (Melnyk & Fineout-Overholt, 2015). When a question is formatted in the PICOT format, it results in the most effective search

and gets the most relevant information. Using the PICOT format, the clinical question for this project was: In adult primary care office patients aged 50 and older (P), does the implementation of an advanced care planning protocol (I), as compared to the current practice (C), initiate provider engagement and discussion of ADs with patients and increase completion and documentation (O), over a 3-month period of time (T).

Significance of the EBP Project

The significance of this EBP project lies in the increased autonomy that qualified patients will gain from the ACP discussion and AD formulation. Goals of this project were to implement measures that would allow the providers to become engaged in ACP discussions and work with patients to ultimately be knowledgeable on and make decisions about their health choices through the use of ADs. Giving the providers the information and support they need to continuously engage patients in these discussions will ideally lead to the increase in AD use and documentation. The goal of increased staff support with ACP discussion and increased AD documentation was designed to be achieved by an easy to use and time sufficient protocol that would include both the providers and the patients. This in turn would allow the patients to become actively engaged in their healthcare choices and allow their wishes for end-of-life care to be known and heard.

Although ACP conversations and AD documentation have been identified by experts as highly important and necessary, they are rarely being implemented into care until there is a crisis. At that point, the patient may no longer be able to make their own healthcare decisions. When a person becomes incapacitated and cannot make healthcare decisions for themselves, the absence of an AD leads to providers being uninformed of the patient's wishes. This leads to undo stress that is placed on family members or other surrogates to make treatment decisions (Beresford, 2017). In times of declining health, families may depend on the providers to make decisions when patients have not directed their care in the form of an AD. Provider-based medical decision making may lead to the performance of treatments that may not align with the

wishes of the patient, such as ventilator support or life-sustaining medications (Beresford, 2017). ACP planning and AD completion should be focused on providing patient autonomy in healthcare decision-making in order to avoid prolonged dying, manage symptoms at end-of-life, achieve a sense of control, and relieve burdens placed on family (Scott et al., 2013). Barriers to implementing ACP and AD discussion are thoroughly identified throughout the literature with strategies to work through them in to give patients the opportunity to formulate and communicate their wishes to their providers, families, and friends. Although the use of ACP and AD discussion is not mandated within the primary care setting, it is highly regarded as necessary for adult patients at all stages of life prior to illness or medical emergencies. The implementation of a protocol or method to increase these discussions and documentation is thus necessary.

CHAPTER 2

THEORETICAL FRAMEWORK, EBP MODEL, AND REVIEW OF LITERATURE

Theoretical Framework

Overview of Theoretical Framework: The Transtheoretical Model of Behavioral Change

The Transtheoretical Model (TTM) is a behavioral model that used to identify specified stages of change in order to predict readiness for individual health behavior change in order to assist in the development of strategies to enable health behavior change (Prochaska & Velicer, 1997). This framework can be applicable to many different situations, behaviors, and populations in order to establish an individual's readiness to change health behavior. The use of the model expanded to include a multitude of other risk-prone health behaviors, including screening and preventative medicine, sedentary lifestyles, medication compliance, and unplanned pregnancy prevention, in addition to many others (Prochaska, Redding, & Evers, 2015). Use of the TTM facilitates change over time with six defined stages of health behavior change. Within the model it is identified that some individual's may move forward and backwards from stage-to-stage, or skip stages all together (Prochaska, Redding, & Evers, 2015). Use of the model also helps to identify what stage of change an individual is in, and how likely or timely they are to making a behavior change (Prochaska, Redding, & Evers, 2015).

The process of change includes ten processes which drive an individual to progress through the six defined stages culminating in a positive behavior change (Prochaska & Velicer, 1997). These ten processes that are defined by Prochaska and Velicer (1997) are useful to include as they are necessary to assist individuals to move forward from stage to stage. These processes are defined as (a) consciousness raising or increasing awareness, (b) dramatic relief to increase emotional experiences, (c) self-reevaluation to help imagine one's self with and without a certain habit, (d) environmental reevaluation to assist in helping an individual to see how a certain habit might affect those around them, (e) self-liberation is the belief that one can

change and the commitment to act on that belief, (f) social liberation includes an increase in social opportunities for patients who are deprived or oppressed, (g) counterconditioning includes that learning of healthy behaviors over unhealthy behaviors, (h) stimulus control removes the cues of unhealthy behaviors and adds the prompts for healthy ones, (i) contingency management is used to provide consequences for taking steps in a particular direction and can include rewards and punishments, and (j) helping relationships, which combines caring, trusting, and open relationships for support of the behavior change (Prochaska & Velicer, 1997).

Prochaska and Velicer (1997) also describe seven critical assumptions that are necessary to drive the transtheoretical theory, research, and practice. These assumptions include (a) that no single theory can account for all complexities of behavior change, (b) behavior change is a process that works over time and through stages, (c) the stages are both stable and open to change, (d) without a planned intervention, the population will remain stuck in the early stages as there is no motivation to move through the stages, (e) a majority of at-risk populations are not prepared for action and cannot be served appropriately by traditional action-oriented programs, so promotion will have much greater impacts if it shifts from an action paradigm to a stage paradigm, (f) specific processes and principles of change need to be applied at specific stages if progress is to occur, so with a stage paradigm, the intervention is matched to an individual based on their stage of change, and (g) chronic behavior patterns are usually with some combination of biological, social, and self-control, so stage-matched interventions are needed to enhance self-controls (Prochaska & Velicer, 1997).

According to Fried et al., (2012) and Erncoff, Keane, and Albert (2016), application of the TTM provides a strong foundation for increasing ACP as a process of behavior change. In the past, the TTM has been utilized as the central organizational construct for promoting change and moving individuals through the stages of change as they prepare to modify their behavior (Fried et al., 2012). Stages of change have been developed and used to measure key components of ACP, such as living will and health care proxy completion. Application of this

model involves assessing individuals state of readiness to complete a certain behavior, such as ACP or AD documentation, and different interventions are applicable to whichever state of readiness the individual is placed into (Ernecoff, Keane, & Albert, 2016). The six stages of change which are defined are pre-contemplation, contemplation, preparation, action, maintenance, and termination.

Precontemplation. The pre-contemplation stage is when an individual has no intention of making a behavior change, usually measured within a six month period of time (Prochaska, Redding, & Evers, 2015). The individual usually has no information on the topic of change, or does have the information but has no desire to make any change in the near future. These individuals may have attempted change in the past with no success, and are usually characterized as resistant or unmotivated. Individuals in this stage generally are not engaged in ACP in any respect (Ernecoff, Keane, & Albert, 2016).

Contemplation. An individual in the contemplation phase has an intention to change their behavior in the near future, usually measured as the next six months (Prochaska, Redding, & Evers, 2015). The individual has some idea of the pros and cons of changing the behavior, and are more aware of the costs and benefits that can be associated with the behavior change. If the individual feels the costs of making the change are greater than the benefits associated with the change, he can become stuck in the contemplation phase, so immediate action programs may not be successful.

Preparation. Individuals in the preparation phase have an intention to make a behavior change soon, usually measured as within the next month or 30 days (Prochaska, Redding, & Evers, 2015). They have begun to think about their treatment values and principles, but may not be ready to plan their actions in respect to ACP (Ernecoff, Keane, & Albert, 2016). Usually, those in this stage have taken some steps toward the behavior change within the past year. They may have some plan of action, such as speaking to another professional, joining an educational class, or buying and looking up information (Prochaska, Redding, & Evers, 2015).

Barriers at this stage may include perceived irrelevance of ACP, such as that they are too healthy, or values and cultural preferences (Ernecoff, Keane, & Albert, 2016). The initiation or introduction of additional educational tools or support from other individuals could help to move an individual forward out of this stage of change and into the next.

Action. Those individuals in the action phase have made some specific modification in their lifestyle, usually measured as within the last six months (Prochaska, Redding, & Evers, 2015). Typically, not all modifications of behaviors are seen as action, as that behavior must be agreed upon as sufficient to reduce a risk, such as getting a colonoscopy if the desired behavior is cancer screening. The individual has completed the initial action or intends to do so (Ernecoff, Keane, & Albert, 2016). The individual may require additional support, such as from a healthcare provider, to eventually move into the maintenance phase.

Maintenance. These individuals in the maintenance phase have already made specific modifications to their lifestyles (Prochaska, Redding, & Evers, 2015). They are working at the prevention of a relapse and do not apply change processes as often as those in the action phase. They are less likely to relapse and have an increased confidence that they can continue this change that have made. The maintenance phase can last anywhere from six months to about five years, depending on the behavior.

Termination. Individuals in the termination phase report having no temptation to return to their at-risk behavior and they have high self-efficacy in maintain the desired behavior change they have made (Prochaska, Redding, & Evers, 2015). Individuals are confident that they will not return to old behaviors, no matter their mood or situation. The new behavior has become automatic to this individual, such as the action of securing a seatbelt when getting in a car. The termination phase is not realistically attainable for all situations, as most individuals will spend a lifetime in the maintenance phase.

Application of the Transtheoretical Model to EBP Project

The TTM is a useful tool and model for tailoring interventions to individuals in need of a behavioral change. Research has shown that this health behavior change model has been effective in improving the completion rate and quality of ADs (Spoelhof And Elliott, 2012). In this instance, the behavior change evaluated will be the thought process accompanied with ACP and documentation of an AD, if they do not already have one. The TTM allows for providers and healthcare professionals to evaluate an individual and determine which stage of change they are currently in. After the stage is identified, the healthcare professional can then be prepared to provide interventions that are efficacious in fostering behavioral change and maintenance.

Precontemplation. In the precontemplation stage, the patient may have no intention of participating in ACP or completing an AD. However, they could also have no knowledge of ADs or have never had any past discussion on ACP (Westley & Briggs, 2004). The individual may have had a bad experience in the past that has caused them to avoid the topic or may have spiritual or religious beliefs and values that prevent discussion. The goal at this stage is that the individual will consider ACP and formulate and ask any questions that they may have. At this stage, the individual should be provided information and encouraged to consider and review the materials. At this time it is also appropriate to provide resources and contact information for future follow-up.

Contemplation. During the contemplation stage the individual is interested in learning more about ACP or ADs, yet may be hesitant to begin the process (Westley & Biggs, 2004). The individual may have some knowledge on ACP or ADs, but barriers may exist. These barriers may include fear or lack of correct information. The goal in this stage is to further educate on ACP and begin providing assistance with the process. The individual in this phase will require additional informational materials and resources and may need questions and concerns answered or resolved in order to progress to the next stage. The individual will also need clarification that these wishes are not final and can be changed at any time throughout their life.

Preparation. In the preparation stage, the individual is prepared to make a behavior change. They are reviewing educational materials, seeking out information, and talking to their family and health care provider. They have a desire to begin ACP (Westley & Briggs, 2004). They are somewhat knowledgeable on the topic and have the tools to begin planning for their future. The goal in this stage is to actively engage in ACP planning and discussions with family or healthcare providers. Providers should make sure that the individual has all the information that they need or require. The provider may need to give more detailed information, but if appropriate, ACP can begin at that time, or a near future appointment can be made to begin the discussion. The individual in this phase may wish to take specific AD forms home to further review and discuss with family and others.

Action. At this phase, the individual is in the process of completing or has completed a written AD (Westley & Briggs, 2004). They may also have already participated in ACP, yet may still need assistance completing the paperwork. The individual in this stage will complete a plan that meets their individually specified goals, such as filling out a living will or health care proxy form. The goal at this stage is that the individual will complete an ACP and AD that meets their individual goals for documentation. The provider will offer information, educational materials, and clarification, if needed, and will reiterate the importance of documenting an AD and ensuring that end-of-life wishes are known. The provider will reassure the patient that changes can be made to AD documentation, as many people may wish to modify their AD as time passes.

Maintenance. At the point the individual reaches the maintenance stage, he has already completed ACP and AD formation. During this stage the individual will require confirmation and reassurance about the ACP. Examples of these may be assurances that all their wishes are documented and forms are complete and on file with their provider (Westley & Briggs, 2004). One goal during this stage is that the individual feels comfortable with their documented decisions and ACP and that the plan will be reviewed and updated as needed. It is necessary

during this stage for providers to ensure that the individual is aware that the ACP will be reviewed and updated periodically to ensure that the document still aligns with the patient's beliefs and wishes, as well as their current healthcare status and needs.

Through use of the model, providers are enabled to quickly identify which stage of change individuals exist. Once providers are aware of the stage of change, they can determine which interventions are most appropriate to facilitate behavior change. Interventions may range from distribution of ACP information to documentation of completion and uploading of the AD document in the chart.

Strengths and Limitations of Theoretical Framework for EBP Project

The TTM provides a practical way for healthcare providers to establish patient specific interventions based on the individual stages of change. An individual's stage of change can be identified through simple and quick questioning, and then the provider can decide and choose which interventions are needed and necessary to begin ACP planning and facilitate the documentation of ADs within the office setting. A great strength of the TTM is that it has been applied across almost 50 behaviors and settings, including primary care, schools, and campuses, and has produced significant results (Prochaska, Redding, & Evers, 2015). Another significant strength is that the TTM is defined as one of the most utilized theories across a broad range of behaviors, with a great deal of documented success. Along with its many strengths, the theory also has weaknesses. A weakness that stands out for this model is that an individual's culture can potentially affect if the stages can be useful in practice. This may occur If a culture does not value specific behaviors, such as ACP. If culture is what holds an individual from ACP conversation, then they will more than likely not progress through the stages and may remain in the pre-contemplation stage.

Evidence-based Practice Model

Overview of EBP Model: Stetler Model

The Stetler Model was chosen for this EBP project as it utilizes a series of five phases to assess research findings to facilitate effective EBP nursing and assist in providing guidance around critical thinking and applying found research to practice (Dang et al., 2015). The Stetler Model was originally developed by Cheryl Stetler and Gwen Marram in 1976 and has been refined three times since (Stetler, 2010). The model was originally created for baccalaureate nurses, but was later more focused on the advanced practice nurse in autonomous practice due to the complexity of the implementation process (Stetler, 2010). This model has been referred to as a practitioner-oriented model because of its focus on critical thinking and use of relevant findings by the practitioner, making this model ideal for this EBP project (Dang et al., 2015).

The Stetler model focuses on accumulation of evidence and substantial findings, and describes how its sources can be categorized by external or internal evidence (Dang et al., 2015). External evidence refers to research and consensus opinion/expert opinions, and internal evidence is described as locally obtained facts or information that assess current practice (Dang et al., 2015). The model is divided into five phases: (a) preparation, (b) validation, (c) evaluation/decision making, (d) translation/application, and finally, (e) evaluation (Dang et al., 2015).

Phase I: Preparation. In the preparation phase, a priority need is defined and confirmed, and a systematic search for relevant evidence, including research, is initiated (Dang et al., 2015). During this phase, the external and internal factors are considered (Stetler, 2001). Internal and external factors can ultimately influence an individual or group's view and use of the evidence that is presented (Stetler, 2001). External factors within the facility that could potentially influence application of a change might include politics, an imposed deadline, or the priority goals of the organization where the change is to occur. Politics may include finances or lack of support from facility leadership. An imposed deadline could have effect as it may impact whether the project has time to develop and run over a sufficient amount of time to collect the necessary outcomes to evaluate for positive change. The intended change not being a priority

for the organization may also be a large external impact on success of the implementation, if the change is not deemed a priority by key stakeholders and leadership support and buy-in will be deficient. Internal factors that may diminish objectivity include personal beliefs or the intuitive appeal of a new intervention (Stetler, 2001). Personal beliefs can impact the success of an implemented change. If individuals feel ADs are not necessary than there may be difficulties in implementing the change. A mix of research, other relevant information, and valuable insights from key stakeholders should be sought and selected appropriately during this phase.

Phase II: Validation. In the validation phase, the evidence that was found in the preparation phase is systematically critiqued. Evidence is critiqued with a focus on utilization potential. This critique differs from the traditional research critique, where findings should be the main item appraised (Dang et al., 2015; Stetler, 2001). In addition to the research critique, summarization of collected findings is performed to identify relationships to identified needs and commonalities should be identified (Dang et al., 2015). Evidence should be sorted into an evidence table and non-credible sources should be eliminated (Stetler, 2001).

Phase III: Comparative evaluation/decision making. During the comparative evaluation/decision making phase, the synthesis of evidence and identified needs help the investigator to decide on a course of action (Dang et al., 2015). Evidence should be logically organized and displayed (Stetler, 2001). While it is possible that single studies may be used by the expert practitioner, the inclusion of multiple studies is preferred (Stetler, 2001).

Recommendations from evidence may transform into an action plan and designate a need for change in practice (Stetler, 2001). Degree and nature of risks, resources and readiness are also be evaluated in this phase (Dang et al., 2015). If sufficient evidence and consensus is found on the need for change, then a plan for change and evaluation should occur (Dang et al., 2015).

Phase IV: Translation/application. In the translation/application phase, the evidence findings from the established need are converted into recommended changes (Dang et al., 2015). A plan is established to detail use of the findings, and then actual implementation occurs

with the evidence-based change plan (Dang et al., 2015). Roles should be established and tasks are specified and assigned (Stetler, 2001). Articulated research findings may not be concrete and may only provide some required details to create a plan of action for change (Stetler, 2001). Gap analysis and organizational systems analysis with consensus, theoretical information, and/or expert judgment are performed in order to fill in blanks (Stetler, 2001).

Phase V: Evaluation. At this final phase, evaluation of the plan by which it was implemented and whether or not the goals for using the evidence were met occurs (Dang et al., 2015). Findings are evaluated and shared with key stakeholders. A formal evaluation may also occur depending on organizational standards. This may include an evaluation by senior leadership or with the institutional review board (Stetler, 2001).

The Stetler Model has defined underlying assumptions that should also be considered when applied to practice. The assumptions include (a) other types of evidence or non-research related findings are likely to be used in conjunction with research findings to facilitate the decision-making and problem solving process, (b) the organization may not be directly involved in the individuals use of research or evidence, (c) utilization may be instrumental, conceptual, symbolic, or strategic, (d) external and internal factors influence an individuals or groups views on evidence, (e) research and evaluation will provide us with inly probabilistic information, not absolutes, and (f) lack of knowledge and skills about research utilization and EBP can inhibit appropriate and effective use (Stetler, 2010).

Application of EBP Model to EBP Project

Preparation phase. In the initial phase, a priority need was established by the project leader and the site facilitator. Through discussion with the patient population and office management, the need for a protocol to facilitate ACP discussion and AD completion and documentation into scheduled office visits was identified. A thorough search of the most relevant and current literature was reviewed in this phase, and the potential for any internal/external factors that could hinder the progression of the EBP integration into practice

were evaluated. Important potential external factors evaluated were the goals of the project site organization and politics. Priority internal factors were identified including determining whether leadership and individual staff found the project worthwhile and necessary for their patient population. Support from the staff and leadership was established through speaking with members of the leadership team, as well as site staff and management. Specific internal factors, such as personal beliefs of individuals involved in the implementation were also evaluated.

Validation phase. Databases examined for this EBP project included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Collaboration and Library, Joanna Briggs Institute Clinical Network of Evidence, ProQuest Nursing, The National Guideline Clearinghouse, and Medline Plus. In the validation phase, evidence found in the initial phase was ranked and placed into an evidence table using Melnyk and Fineout-Overholt's (2015) hierarchy of evidence. Evidence was thoroughly appraised using the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Scale and the Joanna Briggs Institute (JBI) Critical Appraisal on Expert Opinion tool (JBI, 2017).

Comparative evaluation/decision making. During this phase, evidence that was most applicable and appropriate for the EBP project was chosen and displayed within a summary table. Chosen evidence was synthesized and common recommendations between evidence were identified. Any risks associated with the EBP implementation were discussed with the site facilitator and site staff, and staff readiness to change was assessed. A protocol was then established through literature review and developed to fit the needs of the EBP implementation site.

Translation/application phase. Within the application phase, a plan was established to increase ACP discussion and AD completion and documentation rates within the selected office setting between provider and patient. A process was developed delineating tasks and roles and included many of the healthcare team members within the office. Clinical staff, including nurses and the APNs, would follow a previously established protocol to initiate ACP discussion and

document ADs, if the patient desired, and then ensured that the documents were put into the medical record. Front desk staff were to give any patients presenting with a defined appointment selected materials upon checking in. Patients would then be allowed time to look through the information while waiting for their appointment and the provider. Then if the service was not declined, providers would engage the patients in ACP and assist with document completion, if applicable.

Evaluation. In the final phase, the protocol and goals of the EBP project were evaluated, as well as outcomes from implementing the EBP at this clinical site. The effectiveness of the change and whether or not the change was effective and utilized by office staff was determined through the evaluation of these outcome measures and determination of overall efficacy of the project and implemented protocol within the office setting. Project outcomes were discussed with key stakeholders to determine sustainability of the project and conclude if practice change should be continued.

Outcome measures included number of patients who qualified for ACP discussion with the provider and actually received it during their visit, as well as number of new ADss that were completed during the visit. Data was also collected to determine if interventions resulted in a positive progression in the TTM stage. Outcome measures were evaluated by paperwork filed during the visit by the provider. Data was also collected between 4-6 weeks following the visit by follow-up phone call for patients who agreed to be contacted by the project leader.

Strengths and Limitations of EBP Model for EBP Project

Strengths of the Stetler Model include that it is practitioner and critical thinking focused, which make it ideal for this EBP project (Stetler, 2010). This model has a strong grounding in implementation science and a strong relationship with experiences of advanced practice nurses in real-world application. This is necessary with a topic such as ACP with healthy patients. The model ensures that the evidence that facilitated decision making is transparent to the user (Stetler, 2010). The model also identifies alternate types and sources of evidence, other than

research, and can be easily implemented by advanced practice nurses. Although there are many strengths associated with this model, there are also defined weaknesses. The frequent use of critical thinking that is necessary to implement this model may not provide for ease of use for some clinicians, specifically those who are newer or with less experience. The model may also prove to be complex for newer clinicians, making it hard to navigate or implement into practice (Stetler, 2010).

Literature Search

Sources Examined for Relevant Evidence

A comprehensive search of the literature was conducted of multiple search engines to assist in answering the PICOT project question. The database sources that were searched and examined included Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Joanna Briggs Institute (JBI), Cochrane Collaboration and Library, MEDLINE, ProQuest Nursing & Allied Health Source, and National Guideline Clearinghouse. Databases were searched using medical subject heading terms (MeSH) when available, to narrow down keywords for searches and to include the most pertinent information to the posed question. Key words in the searches included the following: “advanced directive” or “advance care planning” and “office” or “primary care”, or “outpatient”. The search results included systematic reviews, qualitative/descriptive studies, quantitative studies, cross-sectional studies, and expert opinions. Through the use of citation chasing in found relevant literature, additional evidence was identified that supported the topic. All searches that were performed were evaluated using the specific inclusion and exclusion criteria.

References that were included within the review fit the criteria of being (a) English language, (b) peer reviewed, and (c) published after 2008. References that were excluded were those ACP events that included adults solely in a long-term care setting, adults in an acute care setting, or evidence that specified use with a specific population of adults with specific disease states, such as congestive heart failure or cancer. Ten articles were extracted, two of which

were found by hand search, from the searches using the inclusion and exclusion criteria (see Table 2.1).

Table 2.1 *Literature Search Summary*

Database	Yielded	Reviewed	Accepted
CINAHL	171	14	2
JBIC	2	2	1
Cochrane	97	2	0
MEDLINE	64	6	3
ProQuest	133	5	2
National Guideline Clearinghouse	776	0	0
Hand Search	0	0	2
TOTAL			10

Levels of Evidence

The evidence that was chosen to be included were leveled based on the Melnyk and Fineout-Overholt (2015) hierarchy of evidence (see Table 2.2). The rating system includes seven levels, with level I considered the highest level and representing the best evidence, and progresses to Level VII, which is considered the lowest level of evidence, and includes expert opinion. The highest rated evidence, Level I, includes evidence from systematic reviews or meta-analysis of relevant randomized control trials (RCTs). Level II includes evidence that is obtained from well-designed RCTs, and evidence at a level III will include evidence from RCTs that are not randomized. Level IV can include evidence from well-designed case-control and cohort studies. Level V evidence can be rated as so if the evidence is from systematic reviews of descriptive and qualitative studies, while a level VI can be defined as evidence from a single

descriptive or qualitative study. Finally, level VII includes evidence that is from opinions of authorities or reports of expert committees (Melnik & Fineout-Overholt, 2015).

Table 2.2 Levels of Evidence

Author(s), Publication. Level of Evidence	Population, Setting	Design, Interventions(s), comparisons	Outcomes and Effect Measures
Durbin, C.R., Fish, A.F., Bachman, J.A., & Smith, K.V. (2010). Systematic review of educational interventions for improving advance directive completion. <i>Journal of Nursing Scholarship</i> , 42(3), 234-241. Level I	<p>Sample sizes ranged from N=137 to N=912 with ages ranging from 26 years to 93 years of age. Population was predominantly women.</p> <p>Of the twelve studies, two were inpatient hospital based, nine were outpatient hospital based, and one was community based.</p>	<p>Systematic review of 12 randomized control trials and 4 non-randomized control trials. Trials were published between 1991 and 2009. Included educational interventions and calculated percent's of newly completed ADs as an outcome.</p>	<p>No single intervention was found to be effective in increasing AD completion.</p> <p>Four of six RCTs showed effectiveness with combined written and verbal interventions versus a single intervention in adult outpatients and hospitalized elderly ($P>0.05$). Differences between Single educational interventions and combined interventions varied from 20.6% to 48% completion rate of newly completed ADs.</p> <p>Written, verbal, and video education was significantly ($p>0.05$) more effective than a single intervention.</p> <p>Combined written and computer education was found to have inadequate evidence.</p>
Fried, T.R., Redding, C., Robbins, M., Paiva, A., O'Leary, J.R., & Iannone, L. (2010). Stages of change for the component behaviors of advance care planning. <i>Journal of the American Geriatric Society</i> , 58(12), 2229-2336. doi: 10.1111/j.1532-5415.2010.03184.x Level IV	<p>N=304 Participants were 65 years of age or older and recruited from two primary care practices and one senior center.</p> <p>Exclusion criteria included a diagnosis of</p>	<p>Observational cohort to develop stages of change measures for ACP to use for engagement and to characterize factors that are associated with readiness to participate in ACP.</p> <p>Measured stages of change for six</p>	<p>Results supported the use of TTM-tailored interventions to promote engagement in ACP. Results suggested that ACP interventions need to assess and target the stage of change the individual is in. Living will completion and ACP communication were associated with an individual's viewed importance of to plan for end-of-life.</p> <p>51% of participants were in the action/maintenance (A/M) phase</p>

	<p>dementia, non-English speaking, significant hearing loss, residing within a nursing home, in an acute episode of illness, and cognitive impairment.</p>	<p>ACP behaviors: (a) living will and healthcare proxy completion, (b) communication with loved ones about life-sustaining treatment and quantity vs quality of life, and (c) communication with physicians regarding life-sustaining treatment and quantity vs quality of life.</p> <p>An AD algorithm made using the TTM allowed for providers to identify patient readiness for ACP and AD completion.</p>	<p>of completing a living will and 34% were in the A/M phase of completing a healthcare proxy. 59% were in the A/M phase for communicating with loved ones about treatments, 10% were in A/M phase of communicating with physicians, 47% were in A/M about communicating with loved ones about quantity VS quality, and 5% were in A/M for communicating with clinicians about it.</p>
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<p>Houben, C.H.M., Spruit, M.A., Gorenen, M.T., Wouters, E.F., & Janssen, D.J. (2014). Efficacy of advance care planning: A systematic review and meta-analysis. <i>The Society for Post-acute and Long-term Care Medicine</i>, 14, 477-489.</p> <p>Level I</p>	<p>Studies included within the meta-analysis were conducted in an outpatient setting during scheduled visits. Settings also included inpatient hospitalized patients. Participants were ages 18 and older. Studies conducted with healthy adults, multiple comorbidities and life-threatening illness, or decreased cognitive statuses.</p>	<p>Systematic review and meta-analysis of 55 randomized control trials. Trial years ranged from 1992-2012. In 26 trials, intervention was classified as focused on advance directive, and 30 trials included communication in addition to advance directives. In 18 trials, completion of advance directives was an outcome.</p> <p>Interventions included written information and hand-outs, communication, video support, chart reminders, group interviews,</p>	<p>Primary outcome measure was completion of advance directives and end-of-life discussions.</p> <p>Secondary outcomes were preference of care and satisfaction of care, decisional conflict, knowledge of ACP, end-of life care preferences, and symptoms.</p> <p>ACP interventions were found to increase AD completion and occurrence of ACP discussions compared to usual care (OR 3.26, 95% CI, $p < 0.00001$)</p>
<p>Howard, M., Bernard, C., Klein, D., Elston, D., Tan, A., Slaven, M.,... Heyland, D.K. (2018). Barriers to and enablers of advance care planning with patients in primary care. <i>Canadian Family Physician</i>, 64, 190-198.</p> <p>Level VI</p>	<p>Population included $n=117$ family physicians and $n=64$ primary care health professionals. Settings included primary care offices throughout Ontario, Alberta and British Columbia.</p>	<p>Cross-sectional descriptive design using a self-administered survey. Results were gathered between November 2014 and June 2015.</p>	<p>Insufficient time, inability to transfer ACP across care settings, decreased interactions with patients near end-of life, difficulty with patients understanding limitations and complications of treatment options were rated as highest barriers.</p> <p>Lack of knowledge and difficulty accessing physician were additional barriers.</p> <p>Enablers were found to be increased engagement, clinician attitudes, creating capacity, integrating ACP into current practice, and system/policy support.</p>

			Lack of time was found to be the greatest barrier and having ACP resources within the office emerged as a main theme to increase ACP discussion.
Le, L, K. (2018). Advance care planning/ advance directive. <i>The Joanna Briggs Institute EBP Database</i> . Level I	Best evidence regarding advance care planning.	Evidence Summary.	<p>ACP is best viewed as a meaningful discussion of preferences while the patient is still able to make them.</p> <p>Evidence suggest as little as 5% of older adults have an AD in place and most patients value ACP discussion with their providers.</p> <p>Multi-component interventions and engaging care planning by skilled facilitators are recommended to increase ACP.</p> <p>Healthcare staff requires ongoing education regarding ACP issues.</p> <p>ACP was found to positively impact end-of-life care in elderly patients ($p < 0.001$) and decrease family stress, anxiety, and depression.</p> <p>A SR found moderate evidence to suggest multi-component interventions to increase AD completion. Interventions included use of skilled facilitators and focusing on key decision makers, such as patients, caregivers, and providers. Lorenz et al. (2008) suggests engaging skilled facilitators and providers to increase rates of effectiveness of communication of end-of-life goals.</p>
Luu, N.P., Nigrin, C., Peairs, K., Dy, S.M., Sawyer, M., Pitts, S., & Petty, B. (2017). Increasing advance care planning completion at an academic internal medicine outpatient clinic. <i>American Academy of</i>	Included a convenience sample of 480 eligible patients from February 2015 to April 2015.	Descriptive design. Documents were mailed to eligible patients 2-weeks prior to appointment. A color-coded form	Of 130 patients who had letters sent to, 96 (74%) presented to the clinic and had forms returned by the clinician. Of the 96, 69(72%) participated in ACP, 34(49%) completed some form of AD document, and 35(51%)

<p><i>Hospice and Palliative Medicine</i>, 54(3), 383-386. Level VI</p>	<p>Patients were 65 years and older in the initial phase and did not have an AD documented in the EHR and were scheduled for a new patient visit or annual visit with the primary care provider.</p>	<p>was given to providers at the visit reminding to discuss ACP. Patients were given the option to watch a short video on ACP prior to provider meetings. Providers marked if discussion occurred, and if not gave a reason why. Following each visit, ADs were scanned into the system.</p>	<p>had a discussion about ACP during the visit.</p>
<p>Puente, K.P., Hidalgo, J.L., Herraiez, J.S., Bravo, B.N., Rodriguez, J.O., & Guillen, V.G. (2014). Study of the factors influencing the preparation of advance directives. <i>Archives of Gerontology and Geriatrics</i>, 58, 20-24. Level IV</p>	<p>Participants included N=246 adults, n=123 who had completed an AD and n=123 who had not ever completed an AD.</p> <p>Participants belonged to two family health centers in the Albacete Health District in 2011.</p>	<p>Analytical Observational Case Control Study. Personal interviews were conducted.</p> <p>Participants were asked 80 questions. Variables included self-perceived health, functional status, morbidity, socio-demographic characteristics, use of health services, attitudes toward ADs and psychosocial aspects.</p>	<p>64.2% of those who had prepared ADs were women and had a mean age of 53.3 years of age. A secondary education (OR=2.5) was also found to be associated with AD preparation, along with living with a partner or child (OR=2.5), chronic medication use (OR =3.2), a high number of specialists (OR=4.0), long-term relationship with a family physician (OR=3.5), and lower level of social interaction (OR=3.0).living with a partner or child (OR=2.5), chronic medication use (OR =3.2), a high number of specialists (OR=4.0), long-term relationship with a family physician (OR=3.5), and lower level of social interaction (OR=3.0).</p> <p>Results showed both socio-demographic situation and health or functional status affects decision to form an AD.</p>

<p>Scholten, G., Bourguignon, S., Delanote, A., Vermeulen, B., Boxem, G.V., & Schoenmakers, B. (2018). Advance directive: Does the GP know and address what the patient wants? Advance directives in primary care. <i>BMC Medical Ethics</i>, 19(58), 1-7. Level IV</p>	<p>502 citizens and 117 GPs. Citizens were 64 years and older, which was the only explicit exclusion criterion. Those who had no mastered the Dutch language and those with other than mild cognitive deficits were also excluded and not approached.</p> <p>GPs were recruited in the Flemish region and without exclusion criteria.</p>	<p>Descriptive Design using a cross-sectional survey.</p> <p>Citizens approached in a public area and given an electronic survey. GP surveys were also in an electronic format.</p> <p>Citizen survey addressed outcomes of notion of an AD, need for an AD and reasons why no AD was drafted yet.</p> <p>GP survey addressed number of ADs drawn up annually, the approach to ADs, the initiator of the conversation, and perceived barriers.</p>	<p>Of the 502 citizens surveyed, 455(90.63%) had heard of an AD, 87 (17.33%) had an AD, 176 (35.05%) wanted an AD, 219 (43.62%) wanted an AD but not at that exact moment, and 21 (18%) never wanted an AD.</p> <p>154 (23.15%) citizens wanted GPs to raise the issue and 214 (34.4%) wanted doctors to explain the AD documents.</p> <p>Of 117 GPs, 65% drafted five or less ADs in the past year.</p> <p>101 (18.53%) citizens had no AD because they believed different options were too difficult to interpret, 89 (16.33%) simply never thought about ADs, and 78 (14.31%) did not know what the documents stood for so had no AD.</p> <p>GPs stated barriers to AD completion as time-consuming (23.11%), lack of experience (15.57%), application too difficult/complex (13.56%), and lack of knowledge (10.55%).</p> <p>Observations confirm previous findings of a low number of signed advance directives.</p>
<p>Spoelhof, G.D. & Elliott, B. (2012). Implementing advance directives in office practice. <i>American Academy of Family Physicians</i>, 85(5), 461-466. Level VII</p>	<p>Examined barriers to AD completion by patients and providers.</p>	<p>Expert Opinion By G. David Spoelhof who is a physician at St. Luke's Hospital of Duluth, Minnesota and specialized in quality of life issues and is an associate professor in the department of Family Medicine and Community Health at the</p>	<p>Authors suggest that AD discussion begin in primary care at routine patient visits at age 50-65 years of age. Patients should be given advance directive forms, forms should be reviewed, and any questions should be answered.</p> <p>Recommendations to readdress the discussion at subsequent routine maintenance visits is also given.</p> <p>Interactive interventions, to provide opportunities to ask</p>

		<p>University of Minnesota Medical School in Duluth.</p> <p>Barbara Elliott is a professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School.</p> <p>Authors examined patient and physician barriers to completing an AD and suggest approaches for including ADs in primary care.</p>	<p>questions, were found to be more effective than didactic interventions.</p> <p>Physician barriers to completing ADs included discomfort, lack of support, reimbursement, and time, as well as waiting for the patient to initiate the discussion.</p> <p>Patient related barriers included fear of burdening family/friends, health literacy, lack of interest of knowledge, social isolation, spiritual, racial, or cultural traditions, and waiting for the physician to initiate the discussion.</p>
<p>Tamayo-Velazquez, M., Simon-Lorda, P., Villegas-Portero, R., Higuera-Callejon, C., Garcia-Gutierrez, J.F., Martinez-Pecino, F., & Barrio-Cantalejo, I.M. (2010). Interventions to promote the use of advance directives: An overview of systematic reviews. <i>Patient Education and Counseling</i>, 80(1), 10-20.</p> <p>Level I</p>	<p>SRLs where at least one of the objectives was to review the effectiveness of interventions to promote AD use with adult patients.</p>	<p>Systematic review of seven randomized control trials and non-randomized control trials.</p>	<p>Interventions were identified to determine their influence on AD completion rate.</p> <p>Evidence showed that use of passive information (leaflets, posters) in conjunction with interactive informative interventions increased AD completion rate in a majority of studies and proved to be the most effective.</p> <p>Patel, Sinuff, and Cook (2004) found that trials utilizing direct patient counseling by clinicians, alone or in conjunction with other educational interventions, showed an increase in advance directive completion (OR 5.95 [1.64, 21.64]; P = .005).</p> <p>Ramsaroop and Adelman (2007) found that in one study AD discussion took an extra 3-5 minutes during a routine office visit, while another</p>

			<p>study reported it took approximately 11 minutes.</p> <p>Lack of time was the main barrier identified in addressing ADs.</p>
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Level I. Houben et al. (2014). performed a systematic review of randomized control trials (RCT) on efficacy of ACP interventions in adult populations with a primary outcome measure of AD completion and end-of-life discussion. This systematic review included 55 studies that met inclusion criteria of English language, adult population, and published between 1992 and 2012. A literature search was performed in Medline/PubMed and Cochrane using key words ACP and AD, end-of-life communications, living will, and end-of-life decision making. Of the 55 studies, fifteen included inpatients, 37 researched outpatients, and four studies used both settings (Houben et al., 2014). After review, interventions in each of the articles were divided into two categories by the authors, those being (1) ADs and interventions that were aimed at completing ADs, and (2) communication and interventions that facilitated ACP discussion. Completion of ADs was reported as an outcome in 18 of the trials. Meta-analysis was completed in 13 of the trials, which were compared and the results included a significant increase in likelihood of the completion of an AD when compared to usual care (OR 3.26; 95% CI 2.00-5.32; $P < .00001$) (Houben et al., 2014). Trials reported increased likelihood of ACP discussion occurrences between patients and providers with intervention, when compared to the control groups (OR 2.82; 95% CI 2.09-3.79; $P < .00001$). This meta-analysis showed that ACP can be effective in increasing completion rates of ADs and occurrences of end-of-life discussion. Authors state that timing of discussion is important and results confirmed the benefits of ACP interventions during

a scheduled outpatient visit, when the patient is not acutely ill and is stable (Houben et al., 2014).

Houben et al. (2014) described that interventions that include communication about ACP greatly improved quality of communication about patient's wishes, end-of-life preferences, satisfaction with healthcare, and overall knowledge of ACP. It was found that patients who were in the intervention groups were much more likely than the control groups to complete an AD and have a discussion with their provider about ACP, and the increased completion of ADs were associated with a decrease in caregiver burden. Authors also state that since patient wishes for end-of-life care is ever changing, regular reevaluation of documents is advised (Houben et al., 2014).

Le (2018) authored an evidence summary on the topic of ADs and ACP and identified the best available evidence in regard to ACP. Le (2018) described a systematic review where there was moderate evidence supporting interventions used to increase AD completion. ACP was found to positively impact end-of-life care in elderly patients when wishes had been known ($p < 0.001$). The importance of reviewing AD documents as time goes on to ensure that preferences have not changed was also discussed, especially in situations where the patient remains mentally capable of making the decisions. The researcher identified that it is important for regular practitioner review of AD documents with patients to ensure the documents reflect the patient's wishes over time. Through this review the researcher was able to demonstrate the value patients have with ACP provider-led discussions, especially when they believe that their preferences and wishes will be upheld. Interventions were also identified, discussed, and demonstrated to be effective in special classes of patients, such as those with end stage cancer, chronic illness, and advanced dementia (Le, 2018). Best practice recommendations include multi-component interventions and provider-engaged care planning to increase ACP. The researcher suggested that patient AD preferences should be discussed upon admission,

that providers should respect and act in accordance with patients documented wishes, and healthcare providers and staff need ongoing education regarding ACP issues (Le, 2018).

A narrative systematic review of randomized control trials and non-randomized control trials was completed by Tamayo-Velazquez et al. (2010) to identify evidence where researchers examined effectiveness of interventions to improve AD completion rates. Seven studies were included and a conclusion was drawn that the most effective method to increase AD completion is a combination of informative material and repeated conversations over clinical visits. Interactive informative interventions, such as face-to-face meetings, in the clinical setting resulted in increased AD completion rates. The researchers included studies which had a main objective of reviewing effectiveness of an intervention to promote ADs, and no specific exclusion criteria was identified. Results were displayed in the form of tables and described interventions and conclusions of results, with statistical data only given for three systematic reviews that included a meta-analysis. Two of the three studies included statistical data that was significant for this EBP project. Ramsaroop, Reid, and Adelman (2007) concluded that the most successful intervention in primary care incorporated direct-patient healthcare interaction over multiple visits, and that passive education without direct-counseling was ineffective in primary care for completing ADs (effect size 0.5). Ramasroop, Reid, and Adelman (2007) also found that primary care providers who spent 3-5 minutes discussing ADs with patients had a completion rate of 44%. Patel (2004) also concluded that interventions that include direct-counseling were more effective (OR 3.71; $p = 0.005$).

Durbin, Fish, Bachman, and Smith (2010) conducted a systematic review of twelve randomized and four non-randomized control-trials based on Cochrane review criteria to analyze evidence that focused on the types of educational interventions used and their outcome on newly completed ADs. Evidence included in this review was published between 1991 and 2009 and focused on randomized control trial studies. Randomized studies identified were used to draw conclusions about evidence and effectiveness of interventions, while non-randomized

trials were used only to report whether interventions resulted in any harm. Findings of the randomized studies were presented in the form of tables with percent of newly completed ADs. Of the twelve studies, eleven included the use of multiple interventions with one study utilizing only computer education as an intervention. The single computer intervention was found to not be effective with the treatment group only having a 0.9% increase in AD completion, and the control group only having a 1.2% increase in completion rates. Three studies within the review had results which demonstrated that written and verbal interventions were significantly ($p < 0.05$) more effective than a single intervention was at increasing AD completion. Studies comparing single versus combined educational interventions depicted percentages of newly completed ADs in the treatment or intervention group ranging from 20.6% to 48%. In the comparison or control group, percentages of newly completed ADs ranged from 0% to 23.9% ($p = <.001$ to $.04$). In the comparison of single versus combined interventions to measure the completion rates of new ADs, Durbin et al. (2010) concluded that there was enough evidence to support the use of combined written and verbal education to increase the occurrences of newly formulated ADs in adult clinic outpatients.

Level IV. Howard et al. (2018) described a cross-sectional descriptive design with a self-administered survey. The survey was used to establish the barriers and enablers of ACP within the primary care setting as described by primary care providers and other healthcare professionals. Results were presented in terms of a mean rating of barriers that were related to the providers, families, and the practice or system (Howard et al., 2018). A mean score of 3 was defined as a moderate barrier and a mean score <1 was defined as a low or less important barrier. Four barriers were rated by physicians and other healthcare providers as a moderate or higher barrier to ACP, and included (a) insufficient time ($P < .001$; mean 3.8), (b) inability to transfer the ACP (mean 3.1), (c) decreased interaction with patients (mean 3.1), and (d) patient's difficulty understanding therapies (mean 3.1) (Howard et al., 2018). Least important physician barriers to ACP were described as perception that the job is to cure (mean 0.6),

perception that patients should initiate the discussion (mean 0.9), and the perception that ACP discussion may negatively affect patient relationships (mean 0.8) (Howard et al., 2018).

Recommended themes for increased ACP in primary care that emerged from providers included: increased public engagement, creating capacity for primary care providers, integrating ACP into the work flow, and increased system and policy support (Howard et al. 2018).

Howard et al. (2018) stated that family practice is a setting in which a relationship is established across the lifespan, and discussions of ACP that are initiated within this setting can ensure that both patients and families are prepared for end-of-life decisions. Howard et al. (2018) also stated that it is a patient expectation that these discussions be initiated by the primary care providers. Howard et al (2018) demonstrated that only a small portion (10%) of adults have ever discussed ACP with their providers.

Fried et al. (2010) completed an observational cohort study with an objective to develop stages of change measures for ACP to measure adult engagement and readiness for ACP discussion through use of a developed algorithm. Measures in this study included: stages of change for six ACP behaviors, completion of a living will and health care proxy, communication with loved ones, and communication with physicians. Participants were 65 years and older and were treated at one of two primary care practices or one senior care center. Patients who met criteria and were eligible to participate were interviewed and categorized by stage of change in the algorithm depending on their answers. Authors found that 51% of those interviewed were in the action/maintenance phase of completing a living will, and 34% were in the action/maintenance phase of completing a healthcare proxy, with 5% and 9%, respectively, being in the preparation phase.

Scholten et al. (2018) described use of a descriptive design with a cross-sectional survey of general practitioners(GP) and recruited citizens. The questionnaire was in a quantitative structure and consisted of multiple-choice answers with some open-ended questions for the physicians (Scholten et al., 2018). The citizen survey questions targeted such

topics as if the citizen had heard of an AD, did they want an AD, if they did not have one at the time what was the reason for it, who did they expect to initiate discussion of an AD, and what did they expect their GP to do for them in terms of ACP and ADs. Of the 502 citizens surveyed, 90% had heard of an AD, but only 17% had a documented AD and 35% wanted to have an AD. Citizens surveys showed that 23% wanted their GP to bring up ACP and 34% wanted the GP to explain the document. The target group of individuals were 64 years of age and greater, and no individuals with major cognitive deficits were included. The GP survey touched on topics of number of ADs drafted in the past year, approach to initiating ACP, and perceived barriers to initiation. Results showed that of the 117 GPs surveyed, 65% or less had documented five or less ADs in the last year. Of those GPs surveyed, 23.11% cited a barrier to AD drafting as lack of time, 15.57% as lack of experience, 13.56% as too difficult of an application, and 10.55% as lack of knowledge (Scholten et al., 2018). Observations confirmed that there were low numbers of ADs that are signed and completed. The researchers demonstrated that citizens surveyed expected that a GP inform and explain what an AD is and that the conversation about ACP be provider initiated.

Level VI. Luu et al. (2017) conducted a descriptive design multi-disciplinary interventional approach to increase ACP at a medical clinic. The primary measure in the study was ACP completion rate. Patients were provided information in the mail 2 weeks prior to their scheduled visit, and providers were reminded of need for discussion by color-coded forms at the visit. There were 480 eligible patients and 327 (68%) completed one or more forms of ACP or had a discussion with the provider. The three top ACP forms completed in the study were state AD forms (47%), medical orders for life-sustaining treatment (MOLST) (45%), and power of attorney designation form (8%). In the initial phase of the intervention, 74% of eligible patients returned to the clinic with information that was sent to them prior to the visit, 72% participated in ACP, and 34% completed some form of AD document. If a patient who qualified did not participate in the ACP discussion, then the clinician documented a reason why, with highest

rated reasons being lack of time, patient already had one, patient refused discussion, and clinician forgot. The intervention was performed a second time with an increased number of letters (683) mailed to eligible patients. The second phase of study had 56% of forms completed by clinicians documenting their ACP outcome, with 67% completing some sort of AD documentation or having an ACP discussion.

Level VII. Spoelhof and Elliott (2012) defined barriers and provided expert opinion recommendations to implementing ADs in the office setting. David Spoelhof, MD is a physician at St. Luke's Hospital of Duluth and a clinical associate professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School. Spoelhof specializes in quality of life issues, which gives him insight and expertise into the issues of ACP and ADs. Barbarra Elliott, PhD is a professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School. The authors provided key recommendations for practice and identified barriers that may be faced by both patients and clinicians in completing ADs. The authors also provide some recommended practices to overcome the identified barriers. Authors recommended that ACP begin at 50 years of age in the context of a routine office visit with a primary care provider, when the patient is still in good health. Authors stated that patients desire to have AD discussions initiated by their primary care providers and documents discussed and explained within their presence to clarify difficult language. The populations needs and interests are the central focus of the evidence, and several resources are made available for AD completion help and information.

Appraisal of Relevant Evidence

The articles selected for critical review were appraised using JHNEBP evidence rating scale and the JBI Checklist was used for text and opinion was utilized for expert opinion articles (JBI, 2017; JHNEBP, 2016). The strength and level of the evidence was ranked utilizing the Melnyk and Fineout-Overholt (2015) Rating System for the Hierarchy of Evidence, using a rating of Level I, being the highest, to Level VII, being the weakest. Evidence as reviewed by the

JHNEBP rating scale was given a rating of high quality (A), good quality (B), or low quality or major flaws (C). A rating of high quality was given to evidence that was consistent and defined results that were generalizable. Additionally, a rating of high quality was given to studies with sufficient sample sizes for the design and those which demonstrated definitive conclusion with consistent recommendations. Evidence was defined as good quality if it had reasonably consistent results, a sufficient sample size, fairly definitive conclusions with reasonably consistent recommendations based on a fairly comprehensive review of the literature. Evidence was given a low quality if it defined little evidence with inconsistent results, had an insufficient sample size for the study design, and had drawn no conclusions (JHNEBP, 2016). No studies that were given a low quality were included within this EBP project.

Using the JHNEBP rating scale, the publication by Houben et al. (2014) was critically appraised (Dang & Dearholt, 2017). Quality was found to be good as results were reasonably consistent and sample sizes were sufficient and large for most included studies. Houben et al. (2014) provided definitive conclusions and consistent recommendations based on the results found in the studies. The literature review was adequate in size, however more studies could have been identified for inclusion and more search engines could have been utilized. Another strength of this review was that it included the outcome measures of AD completion and ACP discussion (Houben et al., 2014). Although this review included interventions in settings excluded from this EBP project, such as acute care, it supported interventions in the ambulatory care setting, therefore its inclusion was key.

Utilizing the JHNEBP rating scale, the evidence summary authored by Le (2008) was critically appraised (Dang & Dearholt. 2017). This evidence summary utilized randomized control trials with meta-analysis and was rated as a level one. Results depicted in the summary are consistent and generalizable to all populations. Although studies included facilities other than outpatient, evidence still supported intervention use in the outpatient setting which increased ACP and AD completion. Recommendations were consistent, and included use of

interventions, such as direct counseling and education (Le, 2018). A strength of this evidence summary was that it included evidence from WHO guidelines, randomized control trials, and expert opinion, and provided best practice recommendations based on findings. Weaknesses include lack of a specified literature review. Overall, the literature provided high level evidence pertinent to this EBP project and was chosen for inclusion.

Howard et al. (2018) was critiqued using the JHNEBP evidence rating scale and found to be of good quality and usable evidence (Dang & Dearholt, 2017). Results and information were clearly documented within tables to justify conclusions and formulated outcomes and statements. A strength of this study is that it was performed solely on primary care providers working in an outpatient setting, making results easily generalizable, and definitive conclusions were made on the highest rated barriers to completing ACP in a primary care setting. A weakness of this study was that, although it is stated that a recent systematic review of relevant literature was performed, no details were provided. With the numerous strengths of this study and the high level of pertinence to the EBP project, this study was found to be of good quality and therefore included.

Results of the study conducted by Fried et al. (2010) were found to be consistent and generalizable, as they included characteristics and descriptions of the individuals and the study was conducted within a primary care facility. Results were clearly displayed within a table stating the participants current stage of change in regards to ACP behaviors. Use of a cohort design was appropriate as the participants were followed over time, although there was no mention of how long participants were followed or a timeline given of how long the study was conducted. Sample size was sufficient for the design, with N=304 participants being included in the study. Study participants were recruited through physician's primary care offices and senior centers, which was appropriate for the study and its exclusion criteria. Recommendations were consistent based on described literature. Evidence was rated and found to be of good quality and appropriate to be included within this EBP project.

Scholten et al. (2018) was also appraised using the JHNEBP evidence rating scale (Gang & Dearholt, 2017). Authors described and mentioned previous studies that have had different results to portray that a comprehensive literature review was undertaken, although methods to review were not depicted. Definitive conclusions were made by the authors about barriers to AD completion and what perceived barriers are within primary care with percentage calculations displayed within a table. The population was large and sufficient for this design with its inclusion of 502 citizens and 117 physicians. Definitive conclusions and recommendations were made from the results of the surveyed participants and described within the discussions section of the study. The interventions included a GP in ACP, making it relevant for inclusion in this EBP project. The evidence was found to be easily generalizable, as the population surveyed included primary care providers and cognitively intact citizens, which are specific inclusion criteria for this EBP project. Using the JHNEBP evidence rating scale this piece of evidence was found to be of good quality and included within the EBP project (Dang & Dearholt, 2017).

The evidence by Tamayo-Velazquez et al. (2010) depicted a wide array of databases searched by the authors for evidence, including those that were non-English language. The patient population within the studies were found to be similar to those utilized in this EBP project, so results were found to be generalizable. Authors described a thorough and comprehensive search of the literature, which included RCTs, systematic reviews, and observational studies. Results were similar and consistent between reviewed studies and were defined throughout the literature by intervention utilized. Results were also clearly displayed with each reference and their corresponding interventions and their results. A strength of this evidence is that most of the included studies were systematic reviews of RCTs that suggested positive results in AD completion from written and verbal ACP discussion. This evidence was rated as high quality using the JHNEBP evidence rating tool and therefore selected for inclusion in this EBP project (Dang & Dearholt, 2017). The systematic review by Durbin et al. (2010) was

rated as high quality, as it had consistent and generalizable results, studies had adequate sample sizes that ranged from 137-912 individuals, definitive conclusions were made on the best and most effective interventions for increasing AD completion, and clear recommendations were developed based upon these findings (Dang & Dearholt, 2017). Further, statistical data was provided within the review and a thorough review literature and evidence was completed.

Evidence in the study authored by Luu et al. (2017) was evaluated by the JHNEBP evidence rating tool and found to be of significance to the EBP project and of good quality, so was selected to be included within the EBP project (Dang & Dearholt, 2017). The study was found to be generalizable as it occurred in an outpatient setting with adult patients over a three-month time frame, which is similar to this EBP project. Results were similar in each phase in regards to number of ACP discussions that occurred, AD documentation, and barriers to discussion. However, in the second phase, even though an increased number of letters were sent prior to scheduled visits, only 56% had forms completed by clinicians documenting ACP outcomes, which may depict a lack of clinician or system support for continuing the intervention in this environment. Recommendations for practice were generated and included: utilizing a multidisciplinary approach to intervention, providing educational material to patients ahead of scheduled appointments, and performing additional interventions for individuals who are involved in the discussion but do not complete an AD document.

The expert opinion evidence authored by Spoelhof and Elliott (2012) was appraised using the Joanna Briggs Institute Checklist for Text and Expert Opinion (2017). As previously described, authors clearly identify themselves within the literature as having expertise in the field of study. The purpose of this reference was clearly defined as examining barriers to ADs. Authors make reference throughout the evidence to previous studies that they reviewed and their results and tie the result of these studies to the current recommendations. A total of seven scientific articles were reviewed and utilized for best practice recommendations. Authors described use of the TTM as a single construct for competing AD documents, and found that the

TTM as applied to ACP can be measured with high reliability and validity. Overall appraisal of the evidence revealed that it was of good quality and was appropriate to be included within the EBP project.

Construction of Evidence-based Practice

Synthesis of Critically Appraised Literature

Specific barriers to ACP in the office setting are clearly identified through the review of current evidence, as well as recommended practices to overcoming those barriers which can result in successful provider-initiated ACP discussions and increased documentation.

(DeVleminick et al., 2013; Howard et al., 2018; Luu et al., 2017; Puente et al., 2014; Scholten et al., 2018; Spoelhof & Elliott, 2012; Tamayo-Velazquez, 2010). Through the review it is clear there are current Indiana standards which depict a perceived importance to the implementation of practices to increase documentation of ADs for residents to ensure that wishes and end-of-life treatment choices are followed (ISDH, 2018).

While reviewing the literature, differences were identified between interventions and effectiveness of those varying implementations, however, common themes emerged throughout. Common themes found throughout the literature were that primary care providers or other clinicians were the main persons involved in the intervention. Additionally, study timelines differed, with some studies occurring over the time frame of a week, and others to almost a year. Interventions and solutions to combatting barriers were a fundamental and common theme for providers and patients throughout most of the literature. The most common barriers mentioned were a lack of time for AC discussions at appointments, lack of education or literature available for providers and patients, discomfort with the topic, providers beliefs that the patient initiate discussions if they wished to discuss ACP, patients believing the provider should initiate ACP discussion, and patients being uninformed about ADs and their purpose (Howard et al., 2018; Scholten et al., 2018; Spoelhof & Elliott, 2012). Interventions used and implemented in the studies evaluated differed, with some proving to be more effective at increasing ACP

discussion and AD documentation than others (DeVleminick et al., 2013; Howard et al., 2018; Spoelhof & Elliott, 2012; Tamayo-Velazquez, 2010).

Providers. Types of provider or clinician that participated in ACP and AD services and interventions differed across studies. Most studies included the primary care provider alone or in conjunction with another clinician, such as a Registered Nurse(RN) or patient educator. Howard et al. (2018) included in their research health care providers and other healthcare professionals, such as registered nurses and advanced practice nurses, within their selected province of Ontario, Alberta and British Columbia. Scholten et al. (2018) similarly included GPs within their research. Participants in the study by Fried et al. (2010) were interviewed by trained research assistants, and providers were not included at this stage of research. Participants in the systematic reviews by Tamayo-Velazquez (2010) and Durbin et al. (2010) define the use of many different professionals to implement the interventions within the chosen studies. In this study, physicians, social workers, patient representatives, and well-informed education leaders ran programs or workshops outside of the clinical setting or during appointments. Lu et al. (2017) included clinicians, front desk staff, clinical coordinators, and administrators in the implementation of their interventions. The ISDH (2017) suggests and recommends that those who need additional information on ADs or who already have one should speak with a physician to clarify wishes about their future health care needs and wants.

Length. The literature reviewed demonstrated that timelines of intervention implementation differed greatly between studies. Howard et al. (2018) provided questionnaires to healthcare providers from November 2014 to June 2015, over about an 8-month period. Scholten et al. (2018) conducted their questionnaires over a smaller time frame, about 6 weeks. The study by Fried et al. (2010), which with the use of interviewers purposively selected their participants, and the systematic review authored by Tamayo-Velazquez (2010) did not state a specific time line for collection of data for any of their studies. Durbin et al. (2010) conducted a systematic review that depicted a multitude of time frames for interventions within the chosen

studies. No clear depiction of exact times the studies ran for were given, but length of time for interventions was displayed within tables. Some patients received the intervention for one day within the office setting, in the form of counseling, a survey or getting materials, and some were followed over weeks to months with interventions, such as follow-up appointments with educational meetings, counseling sessions, or electronic online information (Durbin et al., 2010). Lu et al. (2017) held their intervention over a 3-month period of time, which was similar to the length expected for this project.

Barriers. Barriers were a common finding and discussion of methods to overcome these barriers was key to success when implementing ADs within most of the appraised articles. Howard et al. (2018) describes numerous barriers to the implementation of ACP in primary care, with the leading be an insufficient amount of time during a visit, which Scholten et al. (2018) and Spoelhof and Elliott (2012) similarly describe as the number one barrier to AD discussion and implementation in primary care. Physicians and other health professionals also described an inability to transfer documents, decreased interaction, and a patient's difficulty with understanding life-sustaining treatments as high barriers to ACP initiation (Howard et al., 2018). Scholten et al. (2018) describes additional barriers, as described by the GPs, to AD discussion and completion as lack of experience/knowledge, too difficult of an application, and too emotional. In the citizen surveys by Scholten et al. (2018), highest rated barriers were wanting the doctor to raise the issue or explain the documents and thinking that the documents were too difficult to interpret and understand. Spoelhof and Elliott (2012) also concluded that a major barrier to AD implementation from the patient's view was lack of knowledge, fear of burdening family, and looking for the physician to initiate the conversation. Fried et al. (2010) and Spoelhof and Elliott (2012) state that an important factor that could distinguish whether a person is ready to participate in ACP activities can rely greatly on their willingness to plan for the end-of-life, as well as background characteristics, and socioeconomic status. Cultural, racial, and ethnic

factors may also play a role in a patient's AD completion (Spoelhof & Elliott, 2012; Tamayo-Vazquez, 2010).

Intervention. Howard et al. (2018), through a survey of healthcare providers, found that top suggestions made for increasing ACP discussion in the primary care setting were public engagement, changing health care provider attitudes, creating the capacity for primary care providers, integrating ACP into the everyday workflow, and finding support through the system and policy. Fried et al. (2010) used a formulated algorithm based off the TTM to distinguish at what stage a person was currently in in terms of readiness for change, and more specifically, what stage of readiness they were at for ACP in the clinical setting. The systematic review authored by Tamayo-Velazquez (2010) identified a multitude of interventions within the seven studies that were chosen to increase AD completion rate in the primary care and clinical setting. The most effective method found between studies was interactive education with a provider or professional (Spoelhof & Elliott, 2012; Tamayo-Velazquez, 2010). Tamayo-Velazquez (2010) found additional successful interventions to include assistance with documentation completion, lectures about ADs, guides with key points, reminders to physicians to engage in ACP discussion, and written educational information (Tamayo-Velazquez, 2010). Similar interventions were used in the systematic review by Durbin et al. (2010), who found that providing written materials and direct counseling or education were commonly used. Additional interventions included electronic messages over 8-weeks prompting patients to access an online educational intervention, electronic messages to physicians reminding them to discuss ACP with their patients, providing information prior to the office visit, mailing of AD information and forms to patients following visit, and video education materials. It is also recommended that the AD be reevaluated over time as appropriate to the patient's life stage, and discussions should be initiated that emphasize the patient's goals of care and satisfaction, and family stress (Spoelhof & Elliott, 2012). Initiation of ACP discussions is recommended to begin at routine office visits, between the ages of 50-65 years of age. It is also recommended that AD forms

should be given to the patient and reviewed by the provider at the visit (Spoelhof & Elliott, 2012). Further, it is recommended that if the patient already has a form or document that is filled out and is valid in the state of residency, then it should also be collected and documented or stored within the patient's records (ISDH, 2013).

Best Practice Model Recommendation

Even though evidence suggests patients' desire to discuss ACP with their primary providers prior to health decline, these crucial conversations were not occurring in the clinical site chosen for this EBP project (Houben et al., 2014; O'Sullivan et al., 2015; Puente et al., 2013; Spoelhof & Elliott, 2012). Using the evidence found and common themes among barriers to AD completion, as well as discussions with the clinical site provider, an EBP protocol was defined to facilitate these discussions within the clinic and to increase the documentation of ACP and ADs. Evidence has shown that utilization of the TTM for initiating ACP was found to be an effective model for use within the primary care setting (Fried et al., 2012). The TTM was also found to be an effective measure in increasing engagement of ACP and completion of ADs in the form of living wills and health care proxy designations (Fried et al., 2012).

How the Best Practice Model Will Answer the Clinical Question

The goal of this EBP project was to answer the clinical question, in adult primary care office patients, does the implementation of an ACP protocol initiate provider engagement and discussion of ADs with patients and increase completion and documentation of ADs? Implementation of an EBP ACP protocol allowed the clinical question to be answered by applying the best practice recommendations found and discussed throughout the literature. Recommendations were implemented into a user-friendly protocol that was easily utilized in everyday practice. Implementation of the ACP protocol allowed for assessment of if current practice recommendations would answer the clinical question. Implementation of the ACP protocol provided staff education on AD terms and a review of AD educational materials available. It also assessed for ACP engagement between the provider and the patient and

assisted with documentation of the patients ADs. Through the review of literature, use of the TTM to establish an individual's stage of behavior in regards to ADs was found to be effective in carrying out ACP in the primary care setting (Fried, 2012). Direct interaction and education from the provider to the patient, along with use of educational materials, were found to be effective in facilitating ACP in the outpatient setting (Houben et al., 2014; O'Sullivan et al., 2015; Puente et al., 2013; Spoelhof & Elliott, 2012). A protocol was facilitated with the use of the TTM of health behavior change and the Stetler EBP model, along with best practice recommendations. With the use of EBP recommendations and an ACP protocol, patients had increased autonomy and received the most evidence based information and interventions in regards to ACP in primary care.

CHAPTER 3

IMPLEMENTATION OF PRACTICE CHANGE

In collaboration with key leadership, administrative personal, and the clinical staff, an ACP protocol was implemented over a 12-week period. During this timeframe, patients were provided with educational materials just prior to their office visit, followed by discussions with their providers, and then follow-up occurred through telephone calls to the patient by the project leader 4 to 6 weeks proceeding their office visit to determine their TTM stage advancement and AD documentation. The goal of this EBP project was to authenticate current research supporting the implementation of interventions to increase ACP discussion and AD documentation in a primary care office setting. The implementation of an ACP protocol was found in the evidence to have the potential to encourage providers to initiate discussions with patients and support patient's choices and autonomy in end-of-life wishes. This chapter details the implementation process of an ACP protocol within a selected primary care office setting.

Participants and Setting

Implementation occurred in an outpatient office setting located in the Midwest. Office X was not part of a larger hospital system but had other associated clinics within the Midwest area. The office consisted of two FNPs, two obstetric/gynecologists, and a pediatrician. The office provided care for patients from many of the surrounding towns and had a high daily patient visit count with an average of 60 patients seen per day. As the project included adult patients with wellness or annual visits, the FNPs were invited to participate in this study. The ACP protocol implementation time period was from October 2018 through January 2019, with follow-up data-collection phone calls occurring until February 2019. Staff participants consisted of the family practice providers, front desk staff, patient care coordinator, and the nurses working within the project office site. The primary care providers were responsible for initiating ACP discussion during the visit. Providers consisted of two certified family nurse practitioners,

one of which had been in practice for over eight years and employed at the current office for seven years, and another who had been in practice and employed with the office for over three years. Each provider also had a specific licensed practical nurse (LPN) or medical assistant (MA) working with them, but all were cross-trained to work with each provider. LPN and MA responsibilities included: (a) bringing the patient back to the exam room (b) taking vital signs, and (c) reviewing intake information, such as medications, history, and chief complaint. Front desk staff responsibilities included: (a) checking the patients in, (b) assisting with filling out visit forms, (c) answering phones, and (d) scheduling appointments.

Outcomes

Written permission was obtained to utilize and modify the TTM algorithm from the original author for use in this project (Fried, 2001). Outcomes were measured using the ACP algorithm (Appendix 1) which consisted of six questions with prerecorded responses that the provider selected during the visit. The first question asked patients if they had previously made out an AD. If the patient answered no, a follow-up question by the provider would inquire about how ready they were to complete an AD and if they had (a) not previously thought about it, (b) are not ready to complete an AD at this time, (c) are thinking about completing an AD in the next six months, or (d) are planning to complete an AD in the next 30 days. Patients who had not thought about an AD or were not ready to complete one were placed in the TTM phase precontemplation, while those who were thinking about completing in the next six months were placed in the contemplation phase. Patients who were planning to complete an AD in the next 30 days were placed in the TTM preparation phase. If the patient answered yes, that they have previously made out an AD, the provider would ask if it was within the past 6 months, the action phase, or greater than 6 months ago, the maintenance phase.

The second phase of the protocol inquired about each patients thoughts and knowledge about quality versus quantity of life and included the remaining four questions. Question one was if the patient was aware that some people may not want to live as long as possible if they

have a poor quality of life. If they answered no, then patients were placed in the precontemplation phase and AD information was reviewed before continuing to the next question. The next question asked patients if they had ever thought about whether there could come a time when living a good quality of life would be more important than living a longer life. If the answer again was no, they were placed in the precontemplation phase and AD information was reviewed before continuing to the final questions. The third question inquired about if they had ever talked to their loved ones about their thoughts on quantity versus quality of life. If the patient answered no, then the provider asked about how ready they were to do this in the future. If the patient stated that they had never thought about it or were not ready to discuss with loved ones, then they were encouraged to continue to review the provided AD information and were placed in the precontemplation phase. If patients stated that they were thinking about talking to loved ones within the next six months, then they were placed in the contemplation phase. If patients were planning to talk to loved ones in the next 30 days, they were then placed in the preparation phase of the TTM model. If the patient answered yes to having spoken with loved ones previously, then they were asked if it was within the past six months or greater than six months ago. Those who had spoken to loved ones within the past six months were placed in the action phase, and those who were greater than six months were placed in the maintenance phase. If a patient was placed in the action or maintenance phase, AD documentation was requested to be brought in if previously completed or help with completing forms was offered.

The project assessed if an ACP protocol would increase provider and patient engagement in ACP and increase AD documentation following an ACP discussion. A primary outcome of this project was to establish if the use of an ACP protocol would increase ACP discussions between providers and eligible patients. An additional outcome measured was if patients had advanced in the TTM by a change in the degree of readiness in completing an AD or discussing quality of life versus quantity of life with loved ones. During the initial intervention and ACP conversation, patients were placed in one of five stages of readiness for AD

completion and talking to loved ones about quality versus quantity of life, which included: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance. Patients who consented to follow-up after the initial intervention were then re-analyzed during phone conversations to measure if a change in level of readiness had occurred. An additional outcome analyzed was the amount of AD documents completed during the visit and at one month following the intervention. Statistical Package for the Social Sciences (SPSS) was utilized for data analysis of the measured outcomes (Cronk, 2018).

Intervention

Using the Stetler EBP model and the TTM, a protocol for application into the selected office setting was implemented. Evidence was appraised and interventions were identified facilitating ACP and AD documentation within the primary care office. A date and time were set to educate providers and workers on ACP, ADs, and the protocol being implemented within the office. A short PowerPoint was utilized, and lunch was provided for attendees. The protocol folder being administered to eligible patients was thoroughly discussed with staff, all roles were defined, and all questions were answered.

Patients who presented to the office and met inclusion criteria, age of 50 years or older and in for a complete physical or wellness exam, were given a folder at check-in by front desk staff and asked to review the information prior to meeting with the provider. The patient folder consisted of an introductory letter informing them of the project and its goals, living will and healthcare proxy forms, the Indiana State Department of Health information packet on ADs, and a list of commonly asked AD questions. Also included within the folder was a consent form asking patients to allow the project leader to contact them by phone one month following their appointment. Patients were given time to read through the information during their wait to be taken to the exam room and before seeing the provider. When the patient was taken back to the exam room, a yellow sheet containing the algorithm was placed at the computer by the LPN or MA following completion of the demographic portion to alert providers to initiate ACP discussion

during the visit. Upon entering the exam room, providers would then ask the designated questions and identify on the worksheet the corresponding TTM stage based upon the patients response. The provider would then inquire if the patient had any questions related to ACP. If an AD document was completed, it would be collected at this time and scanned into the medical record with the original then returned to the patient. Proper documentation of the document and patient status would then be charted by the provider on the algorithm worksheet. If follow-up was needed, then an appointment would be scheduled for a later date. One month following the appointment, the patient would be contacted by the project leader for follow-up to evaluate if a change in TTM stage had occurred, if an AD document was drafted, or if there were any further questions after review of the provided paperwork.

During the intervention, changes had to be made to the first stage of the protocol. Front desk staff were changing frequently and had a difficult time distinguishing between patients who qualified for the protocol and those who did not. The site had a patient care coordinator (PCC) who was available to the FNP's five days a week to educate patients on health promotion. As educating patients on the protocol was congruent to the role of the PCC, this task was reassigned to the PCC. Folders were then given to patients by the PCC when they were brought back to the exam room, as they were being admitted by the LPN or MA.

During the course of the intervention, it was also found that the LPNs and MAs assignments were changing frequently throughout the site. Additional education was given to each new LPN or MA in the form of the ACP presentation including a review of the algorithm and documents in the patient folders. A detailed list of required information, including collecting the patient's demographic information and consent was also posted above the computer station as a reminder tool. The PCC was also thoroughly educated on the LPN and MA duties, so if necessary, education to staff could occur in the absence of the project leader.

Planning

The project leader met with key stakeholders and leaders within the project site office six months prior to intervention implementation to discuss a need for change in ACP conversation and AD documentation. The project proposal was presented and accepted by the site facilitator, management, and company leadership. The project proposal was then submitted to Valparaíso University Institutional Review Board (IRB) and approval was granted prior to implementation. An education session was provided for staff prior to the protocol implementation with document introduction and an informational PowerPoint, to ensure roles were clear and all questions were answered. Implementation began on October 10, 2018 and continued through January 2, 2019 with follow-up phone calls extending to February 1, 2019. Through conversations with staff, management, and patients, it was found that the facility had a need for increased ACP discussion, education materials, and documentation. An ACP protocol offered the site an EBP approach to increasing patient autonomy and ACP discussions with their adult population.

Data

Measures

Data was collected by the providers and the project leader using the TTM algorithm. Outcomes measures included the patients stage of readiness during the initial intervention and meeting with the provider, as well as their stage of readiness following the intervention at follow-up. Patients who agreed to take part in the ACP discussion were asked a series of six questions by the provider. Following each question, the provider would then identify the stage of readiness the patient was currently in depending on the patients response. Stages of change included:

- Precontemplation: Patients were placed in this stage if they had not previously thought about AD completion or were not ready to complete an AD at this time. Patients were also given this level if they had not talked to loved ones about quality versus quantity of life or if they were not ready to discuss it at this time.

- Contemplation: Patients were placed in this stage if they were thinking of completing an AD in the next six months or if they were thinking about talking to loved ones about quality versus quantity of life in the next six months.
- Preparation: This stage was given to patients who planned to complete an AD within the next 30 days or who planned to speak with loved ones about quality versus quantity of life within the next 30 days.
- Action: Patients were placed in this stage if they had completed an AD within the past six months or had spoken to loved ones about their thoughts on quality versus quantity of life within the past six months.
- Maintenance: This stage was chosen for patients who had a completed AD for greater than six months or had spoken with loved ones about their views on quality versus quantity of life greater than six months ago.

The TTM algorithm was utilized in previous research by Fried et al. (2010) and found to be reliable in data collection pertaining to this subject. Measured outcomes were assessed using SPSS.

Collection

The intervention took place during all wellness visits and complete physicals during the 3-month period of October 2018 to January 2019 with one-month follow-up calls extending into February 2019. A yellow paper protocol sheet was administered in each patient's room who qualified for ACP discussion. LPNs and MAs would gather patient and demographic information listed on the front of the algorithm sheet, such as; date of appointment, provider, age, gender, race, marital status, and presence of chronic disease states. LPNs and MAs were also responsible for obtaining a patient consent signature and phone number for follow-up during the appointment. The yellow algorithm worksheet was then left at the computer for the provider to fill in the remaining information on the back. The provider would then initiate ACP discussion during the visit and document the patients level of readiness, from precontemplation to

maintenance, by asking the six listed questions and selecting the corresponding level dependent on the patients response. A change in level of readiness to complete an AD or talk to loved ones about quality vs. quantity of life was obtained and evaluated from the patient's responses at follow-up phone calls. During the follow-up phone calls, if the patient was in the precontemplation stage, the project leader asked if information was reviewed and if any changes had occurred, such as thoughts to complete an AD in the future. If the patient was in the contemplation or preparation phase, then the patient was asked if an AD had been completed after the intervention, or if they had spoken to loved ones about their thoughts on quality vs. quantity of life. If the patient had initially been placed in the action or maintenance phase, the patient was asked if they had any additional questions or concerns about ADs or quantity vs. quality of life, and if they had brought in or planned to bring in already established AD documentation at future appointments.

Management and Analysis

A comparison was done of patients who met eligibility criteria for ACP discussion and received it to those who did not over the 3-month intervention period. Comparison was done by receiving the number of eligible patients who met inclusion criteria during the intervention from information obtained by the facilities data analyst. A percentage was then calculated of how many patients qualified and how many received ACP during the 3-month period. Patient demographic data was analyzed by descriptive analysis of frequency based on their gender, age, race, and chronic diagnosis. SPSS software was utilized to assess measured outcomes. A chi-square test was performed to compare level of readiness data collected from the algorithm worksheet during the initial intervention and at follow-up.

Protection of Human Subjects

To ensure that protection of human subjects occurred, the project leader completed the National Institute of Health's "Protecting Human Research Participants" training course. The course included education and guidelines for the inclusion of human subjects to ensure their

safety. Safety and rights of all participants in this EBP project were a primary focus throughout the project.

The project proposal was submitted to the Valparaiso University's IRB and approval was obtained. After obtaining approval, the proposal was then brought to the target office sites management for review, as no formal IRB process was required from the site. Participation in this project was voluntary. Patient consent was gained verbally and in writing for inclusion in the project and permission was obtained from each patient for the project leader to call one month following their ACP conversation. Patients were informed of the project and its goals through an introductory letter, which was distributed during the admission portion of their scheduled appointment. Patients were able to decline participation in the ACP discussion.

To ensure privacy and anonymity of the participants, all collected protocols were locked in a filing cabinet at the site facilitator's desk. All personal information, including patient name and phone number, was blacked out and removed from the algorithm worksheet. Each completed protocol was placed into a folder at the site facilitators desk during the work day and locked in a drawer at the completion of each work day. Forms were then collected by the project leader and placed and kept within a locked drawer at leader's personal desk. All data sheets collected were destroyed following completion of this project.

CHAPTER 4

FINDINGS

The purpose of this EBP project was to increase ACP discussions in an effort to increase AD completion rates in this practice. This was to be accomplished with a standardized protocol, implementation of educational material for both providers and patients, and an increase in support providers had in regards to initiating ACP and AD discussions.

Implementation of an ACP protocol focused on initiating AD conversation between providers and patients has been shown to improve ACP rates and AD documentation. This EBP project utilized Indiana State AD information for education of providers and patients, an ACP protocol sheet to lead AD discussion for qualified patients, and the use of follow-up phone calls to identify changes in level of behavior and any AD documentation following the visit. The PICOT question that was the foundation for this project was, “ In adult primary care office patients aged 50 and older, does the implementation of an advanced care planning protocol, as compared to the current practice, initiate provider engagement and discussion of AD with patients and increase completion and documentation, over a 3-month period of time?” This project was implemented and both subject characteristics and outcomes were analyzed.

Participants

Size

Over the 12-week course of the intervention, 115 patients presented for wellness or physical exams, between the two providers, that qualified for the intervention. A total of 53 patients were invited to participate in the evidence-based ACP discussions giving a 46% completion rate for the intervention. Of the 53 patients, 50 participated in the in-office discussion with the provider and consented to follow-up 4 to 6 weeks following the discussion giving a 94% response rate. Each participant was given the same educational materials prior to the visit and were asked the same list of questions pertaining to AD completion and knowledge of quality

versus quantity of life. One patient was lost to follow-up giving a 98% response rate for the participants that were included in the ACP discussion. Results from the 50 pre-implementation and post-implementation algorithm responses were included within the data analysis.

Characteristics

Ages of participants ranged from 50-72 years of age, with a mean age of 56 and a standard deviation of 5.5. Of the participants (N=50), more than half of the included participants were female (see figure 4.1). Demographic information of participants were also analyzed. Of the 53 patients, 66% were Caucasian, 19% were African American, 4% were Asian, 9% were Hispanic, and 2% identified as other (see figure 4.2). Marital status of participants were also collected and analyzed (see Figure 4.3). Of the included participants, almost half (45%) reported that they were married, 28% reported that they were divorced or separated, 20% stated they were single, and 7% were widowed. The final characteristic gathered and analyzed of participants was presence of any chronic diseases (See Figure 4.4). Within the sample population, 60% stated they had hypertension, 36% had diabetes mellitus, 15% had chronic obstructive pulmonary disease, 9% had coronary artery disease, 2% had congestive heart failure, 8% had or currently was diagnosed with cancer, 2 had a previous stroke, and 51% had some other nonidentified chronic illness.

Figure 4.1. Gender

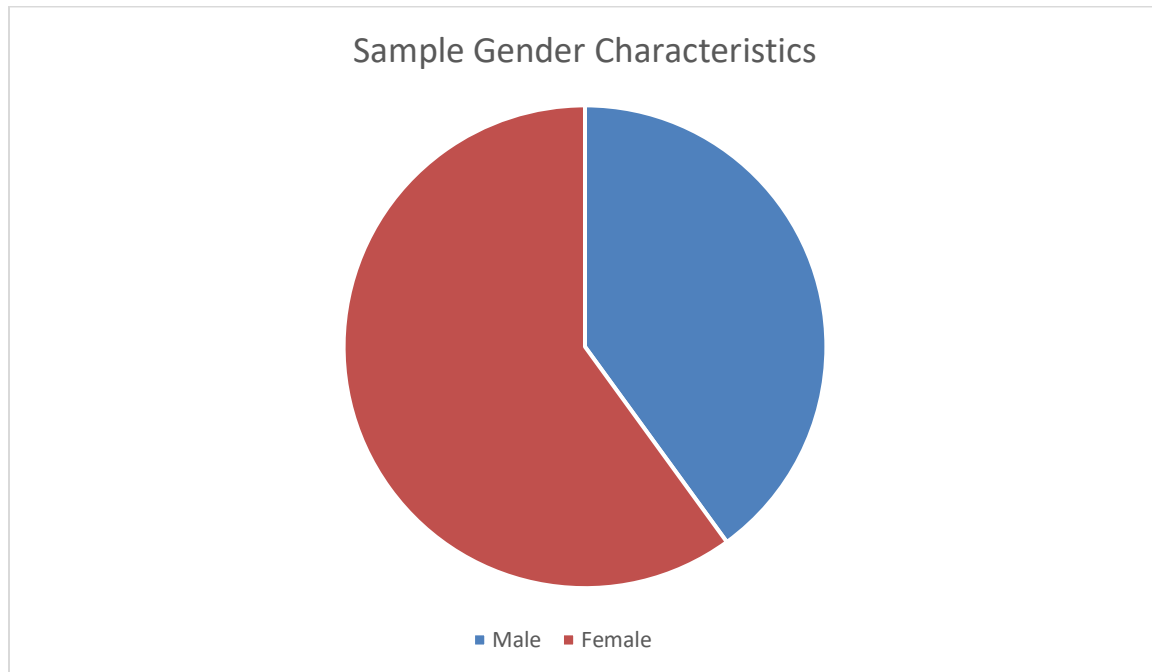


Figure 4.2. Race

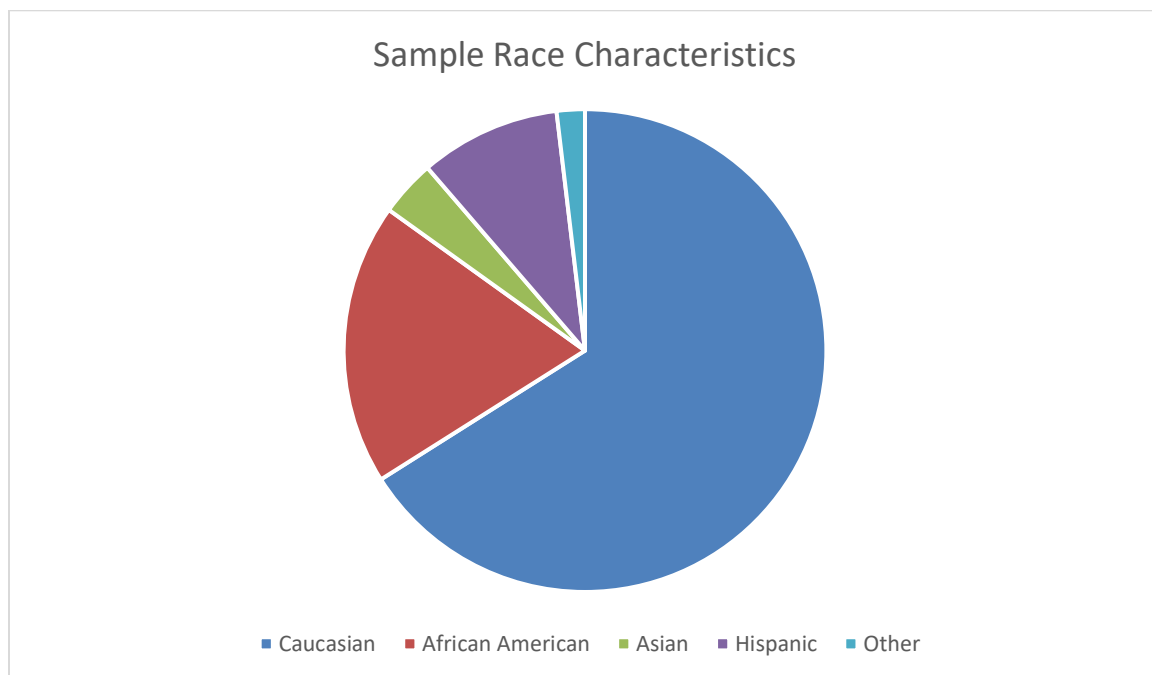


Figure 4.3. Marital Status

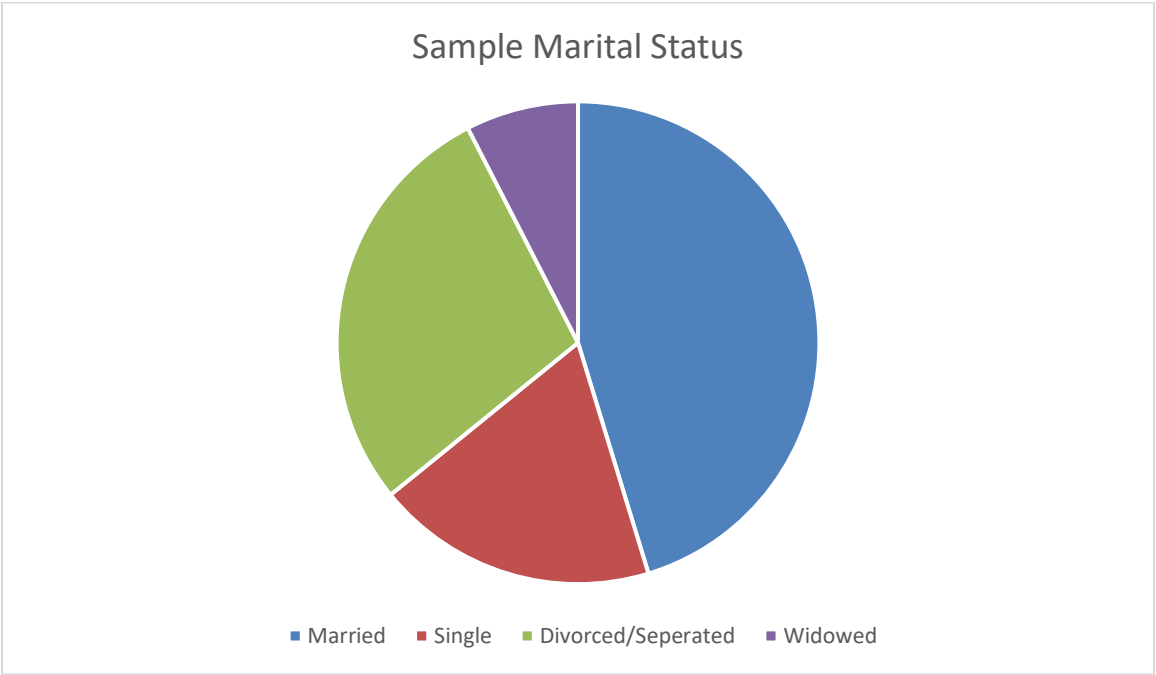
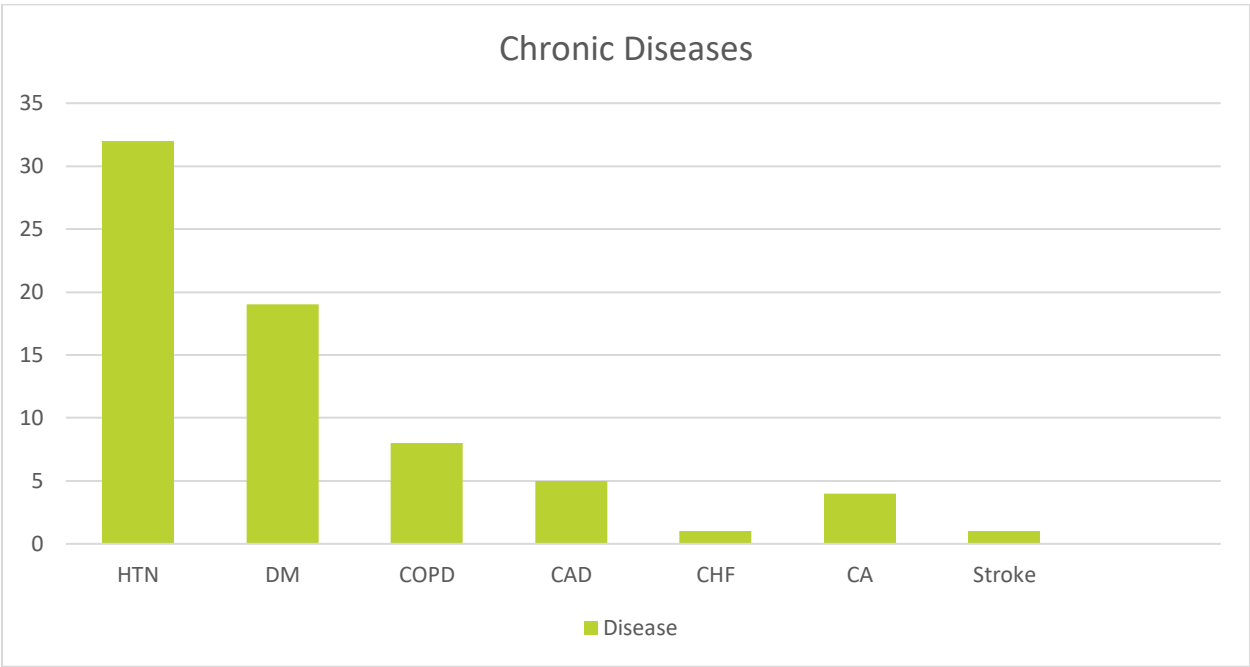


Figure 4.4. Chronic Disease



Changes in Outcomes

Statistical Testing

Data were entered into SPSS to be analyzed. Fried et al.(2012) found the TTM algorithm for the use of ACP to be a reliable and consistent measure in ACP values and beliefs. Additional testing for internal consistency and reliability of the specific population was undertaken by use of a Cronbach's alpha from the available participants data. A value of 0.749 was obtained, demonstrating strong internal consistency of Fried's (2010) TTM algorithm utilized during the intervention. A chi-square test was utilized to analyze if a significant change in participants stage of behavior prior to ACP discussion and following discussion occurred.

Significance

Data were collected using Fried's (2010) six question TTM stages of change algorithm for ACP. Participants were determined and classified into the appropriate TTM stage and given a stage ranging from 1 (precontemplation) to 5 (maintenance) in categories of ADs and quality versus quantity of care. A total of 115 patients were found to be eligible over the 12-week period to receive the ACP protocol, and of those individuals, 53 (46%) were offered inclusion into the EBP project. Of the 53 offered inclusion in the EPB project, 50 (94%) participants agreed to take part in the ACP during their wellness or annual physical visit. Three eligible individuals over the 12-week period refused to take part in the ACP. During the visit, 2 (4%) ADs were completed, and 3 (6%) ADs were documented at the clinical site. Of the three ADs documented, one included a participant who had current ADs and had the documents at the visit. Follow-up occurred via telephone call 4 to 6 weeks following the initial ACP discussion. One participant was lost to follow-up, but 49 (98%) were able to have data analyzed for follow-up. A total of 22 (45%) ADs were completed after the ACP discussion. Answering the PICOT question, that with the initiation of a protocol, ACP discussions and AD completion and documentation rates would increase from baseline. Data was also found to be significant for an alpha of 0.05 when attempting to detect a significant degree of change from pre to post TTM stages of both ADs

($X^2 = 136.900; df(25); p = .000$) and quality vs quantity of life ($X^2 = 156.754; df(25); p = .000$). Change in TTM stage for participants who were stage 1 (precontemplation) at the initial visit were also analyzed. It was found that at the initial visit prior to intervention, 48% ($n = 24$) identified as a stage 1 for ADs. Of those participants who were stage 1 pre-intervention, 4% ($n = 1$) remained at stage 1, 54% ($n = 13$) progressed to a stage 2, 13% ($n = 3$) changed to a stage 3, and 29% ($n = 7$) moved to stage 4 by the time of follow-up. Of all 49 participants available for follow-up, 2% ($n = 1$) were still at a stage 1, 27% ($n = 13$) were at a stage 2, 14% ($n = 7$) were a stage 3, 49% ($n = 24$) were a stage 4, and 8% ($n = 4$) identified as a stage 5 in AD staging (See Figure 4.5). In the quality versus quantity TTM staging, 12% ($n = 6$) were determined to be at a stage 1 prior to ACP discussions. Of those staged at level 1 pre-intervention, 17% ($n = 1$) remained a stage 1, 66% ($n = 4$) progressed to a stage 2, 17% ($n = 1$) progressed to stage 3, and none identified as stage 4 or 5 at follow-up. At follow-up, in the category of quality versus quantity, 2% ($n = 1$) remained at a stage 1, 12% ($n = 6$) were at a stage 2, 8% ($n = 4$) were stage 3, 53% ($n = 26$) were at a stage 4, and 25% ($n = 12$) stated they were at a stage 5, or in the maintenance phase (see Figure 4.6). A significant overall change was found in progression of TTM behavior stages in both ADs and quality vs. quantity following the ACP discussions.

Figure 4.5. AD TTM Staging Pre and Post Intervention

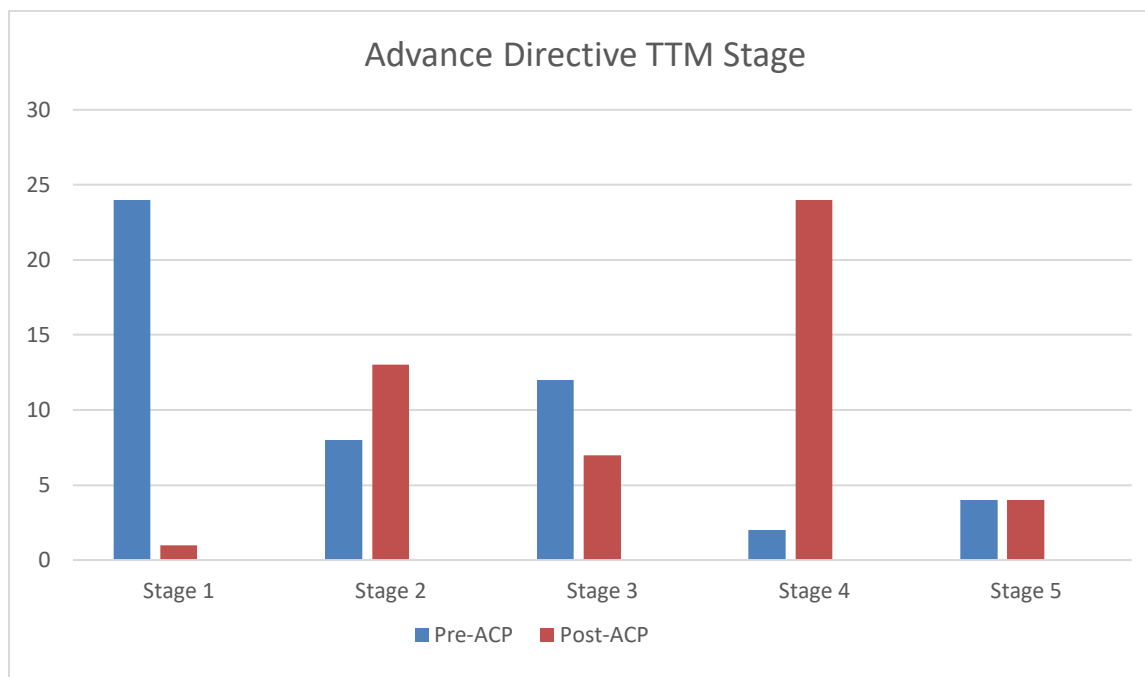
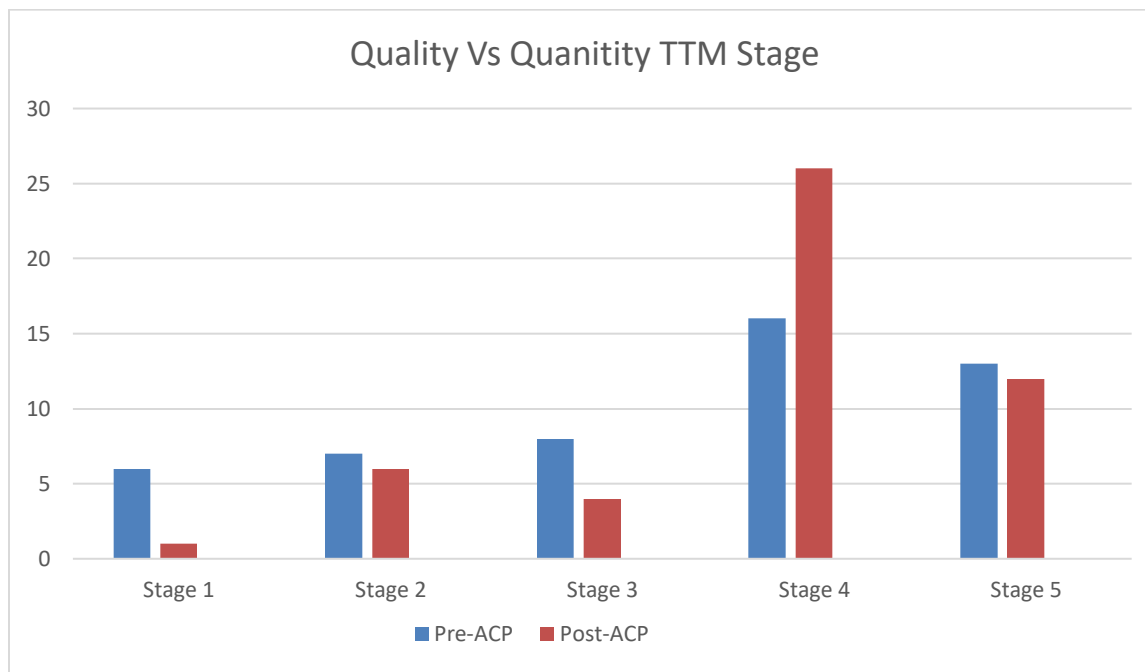


Figure 4.6. Quality Versus Quantity TTM Staging Pre and Post intervention



CHAPTER 5

DISCUSSION

The purpose of this evidence-based project was to determine if implementation of an advanced care planning (ACP) protocol would increase ACP discussions, AD completion, and result in a modification in stage of change or behavior. This EBP project examined the effects of initiating an ACP protocol and answered the following PICOT question: In adult primary care office patients aged 50 and older, does the implementation of an advanced care planning protocol, as compared to the current practice, initiate provider engagement and discussion of ADs with patients and increase completion and documentation, over a 3-month period of time? Within this chapter, findings will be discussed, as well as a detailed evaluation of the theoretical and EBP framework. Strengths and weaknesses of the EBP project will also be examined, and implications for future projects will be addressed.

Explanation of Findings

Overall, ACP discussion rates, AD completion rates, and AD documentation increased after implementation of this project. Prior to implementation of this project, there were no ADs documented in the EHR system, and there was no ACP occurring for any of the clinics patient population. During the visit, 4% of those who received ACP documented a form of AD, and post implementation, 45% of those included in the EBP project intervention had completed a form of AD, with 6% being documenting at the facility. The goal of this project was met with the participants partaking in the ACP discussion during their wellness or physical examination, as well as by consenting to follow-up at 4 to 6 weeks post-implementation. The increase in ADs completed, ACP discussions, and ADs documented highlights the importance and need for continued ACP in the primary care setting. The high amount of patients who progressed from stage 1(precontemplation)(48%) pre-intervention to stage 2(54%), stage 3(13%), or stage 4(29%) shows that ACP and given materials were beneficial to the patients overall education

and knowledge of ADs and ACP. Quality versus quantity education was also shown to be effective, as 66% of the participants who were placed at stage 1(precontemplation) pre-intervention, moved to a stage 2 post-intervention.

With the inclusion of basic AD information and ACP at a wellness or annual physical exam, patients were shown to have a significant degree of change in TTM AD stage ($p=.000$) and quality versus quantity staging ($p=.000$). These results signify that a significant change in stage of the TTM occurred in both AD and quality versus quantity of life questions from pre-intervention to post-intervention, demonstrating the great potential for increased knowledge and education for patients in the primary care setting. Only having one patient lost to follow-up also emphasizes the importance placed on ACP by the participants, as follow-up phone calls averaged 6 minutes, with the patients asking additional questions and thanking the project leader for including them in the intervention.

Evaluation of Applicability of Theoretical and EBP Frameworks

Transtheoretical Model

Use of the TTM has been found to provide a strong foundation for increasing ACP as a process of behavior change (Erncoff, Keane, & Albert, 2016; Fried et al., 2012). The TTM has been utilized as a central organizational construct for promoting change and moving individuals through the stages of change as they prepare to modify their behavior (Fried et al., 2012).

Research has shown that the health behavior change model has been effective in improving the completion rate and quality of ADs (Spoelhof And Elliott, 2012). The TTM predicts readiness of health behavior change and readiness in an individual through the use of five defined stages (Prochaska & Velicer, 1997). The TTM places individuals in a series of readiness to complete a certain behavior, such as ACP or AD documentation, and different interventions are applicable to whichever state of readiness the individual is placed into (Ernecoff, Keane, & Albert, 2016). The five stages of readiness in the TTM included: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, (5) maintenance. The AD engagement protocol, detailed by Fried et al.

(2010), gave providers the support necessary to initiate ACP discussion with selected patients. The use of the TTM easily guided the providers in determining patient readiness for ACP or AD information, and based on patient answers, provided clear suggestions on interventions based on level of readiness. The TTM level of readiness afforded the providers with clear direction on how to approach ACP and ADs with patients dependent on their level of readiness in regards to ADs and quality of life. Use of the TTM gave providers the ability to decide whether a patient was receptive to ACP, needed further information, or was at a level of readiness where AD documentation could be obtained.

Stetler Model

The Stetler Model was chosen for this EBP project as it utilized a series of five phases to assess research findings to facilitate effective EBP nursing and assist in providing guidance around critical thinking and applying found research to practice (Dang et al., 2015). This model is a practitioner oriented model, and since the practitioner was a main change agent in the implementation of the project, this model was a good fit. The model consisted of five phases that were utilized to guide the research for the projects and assisted in the development and implementation of the project. The preparation phase provided and confirmed a need for the project through a systematic search of relevant evidence. Goals of the organization where the change was to occur were evaluated, and support from leadership members was obtained to allow for the intended change to occur. The second phase, validation, allowed for a thorough critique of the evidence. Phase three, comparative evaluation/decision making, consisted of organizing and displaying the critiqued evidence to ensure that sufficient evidence was found to show a need for change. The fourth phase, translation/application, converted found evidence into recommended changes and specified roles and established tasks to be assigned. In the final phase, evaluation, the plan as a whole is evaluated and whether or not goals were met is analyzed.

Modifications were necessary to be made to the original translation/application phase outlined in chapter two. Implementation of the project began with front desk staff giving the information folders to qualified patients when checking in for their appointments. However, qualified patients were determined to have been missed at check in. This was determined to be due to the lack of knowledge of the front desk staff regarding which patients should get the AD information, low staffing of front-desk, and variability of staff assigned to work the front desk. Frequent re-education was provided to front-desk staff, however patients continued to be missed. A decision to change the initial implementation was made to ensure that most patients were given the opportunity to participate in the project if they qualified and consented to participate. The patient care coordinator (PCC) was amenable and tasked with providing the patients with the information folder when brought back to the exam room, prior to meeting with the provider. The PCC would then alert the nurse or MA to gather the demographic information and leave the yellow algorithm worksheet at the computer for the provider to initiate ACP. Continuity of nursing and MA staffing at the clinic was also variable due to the rotation of these clinicians at various clinical sites. Education sessions were provided frequently by the project leader, as well a developed and posted education to remind staff of the protocol and what information required collection at the time of the patient visit. In the future, it is recommended to implement with a system that can utilize alert systems to remind front desk staff to provide the necessary information. Further, it would be helpful to have continuity of staff assigned to tasks necessary for ACP.

Strengths and Limitations of the EBP Project

Strengths

The strength of this EBP project was apparent with the success of implementation of the ACP protocol and the impact on both the patients and staff. Giving the providers and staff education on ACP and ADs alone was monumental for some who were not familiar with their meanings, uses, and the infrequency of utilization. Providing education and a delineated

protocol and algorithm provided staff the guidance they needed to initiate ACP with willing patients and encourage AD knowledge and completion. An additional strength of this EBP project was that it was highly accepted within the office and among leadership. The successful implementation of this project increases its transferability and can allow for its use in similar office settings. With the office's busy schedule and the high patient loads that providers had daily, support was a necessity to ensure staff compliance to implementation and ACP engagement was performed within the limited time of a scheduled office visit. Patients also expressed a high level of acceptance with ACP, as many described a lack of knowledge on the topic, or general unawareness of when to bring the topic up with healthcare providers or family members. It was found that many were receptive to the initiation of these discussions in a safe environment with their provider. As an added benefit, this project was helpful in identifying which patients already had an AD document but did not have one on file at the clinic. After speaking with management and company leadership, a new charting area and heading, specifically for documenting ADs and ACP discussion, was implemented into the EHR. Providers now have easy and simplified access to patients ADs, which was not available prior to the implementation of this EBP project. Use of the ACP protocol and algorithm also added significant strength to the project, as it was shown within the literature and with the specific patient population to have a positive reliability and validity for the use of ACP discussion.

Limitations

A major limitation of this project was the inconsistency in identifying all qualified patients. This was due, in part, to inconsistency of front desk staff providing AD information folders to incoming qualified patients. When patients were scheduled incorrectly for visits, including when chronic patients arrived for their annual exams, then they were missed for inclusion in the project. Additionally, if the patient did not have an algorithm sheet left in the room by the nurse or MA, the provider was not aware that ACP was to occur via the protocol. Identifying all qualified patients correctly and ensuring their receipt of AD information would have expanded

the number of patients included in the project and could have provided a more positive outcome in the number of patients engaged by the health care providers. Another limitation of the project was the high number of front desk staff, nurses, and MAs who were frequently changing during the project. Education was ongoing throughout the project in order to ensure that new staff was aware of their role in the protocol and that patients were not missed. However, with this limitation on inconsistent staff, patients were missed or not included due to lack of education on their role in the protocol, or lack of awareness of what information needed to be collected. An additional limitation of the project was the change in work hours of one of the providers at the start of the implementation. The full-time provider was sent to a sister facility to cover open needs, so a decrease in available and eligible patients was seen in the project office. If providers had been available more within the project office, there may have been an increase in patients who received the intervention and were engaged in the ACP protocol. Unfortunately, cultural factors in ACP were not depicted well throughout the literature, and this project did not assist in any additional findings. According to Wesley and Briggs (2004), cultural and racial attitudes can play a major role in ACP and end-of-life wishes. Hispanics comprised only 9% ($n=5$) and Asian accounted for only 4% ($n=2$) of participants, giving limited data toward different cultural backgrounds and their use of ACP. The final limitation was the restriction to age and visit type. Many of the participants family members or significant others, who were also present for separate individual appointments, wanted additional information or ACP advice from the provider. Due to the restrictions of the project, these patients were not included in the intervention, so making changes to the inclusion criteria of patients in the future could potentially increase the number of patients who receive ACP and increase AD rates and documentation.

Implications for the Future

Practice

The incorporation of the PSDA allowed for specific healthcare facilities, including hospitals and nursing homes, to provide information to and keep records of ADs on patients

before serious illness or injury occurred. Nurses are known for advocating for patients and have the skills necessary to facilitate AD education. Staff nurses are supporters of AD discussions and can provide the needed education during a hospitalization or other healthcare facility stay and encourage those who may defer ACP at that time to speak with their primary health care providers at their next scheduled visit.

In practice, APNs can play a major role in ACP for patients since they are at the front lines of practice and seeing the patients in the office settings. Wellness or other periodic visits prove to be an ideal environment for the provider to incorporate ACP and discuss and promote ADs. Providers can answer any questions that patients have pertaining to ACP and can assist with further direction based on specific requirements of ADs and can help to develop and plan ADs. APNs work to provide their patients with high quality, cost-effective care, and are advocates for the care of their patients. With the inclusion of ACP in their visits, they can give their patient the opportunity to voice and document their decisions on end-of-life care. Providers are also in-turn promoting cost-effective future care with the use of ACP, as end-of-life care therapies can be costly and can be avoided if the patient chooses.

Theory

The TTM framework was essential to the success of this EBP project. In research the TTM has been shown to be applicable in assisting and guiding behavior change. When a change is identified as a need, the TTM can define the stage a person is currently in and show their readiness to make that change. This project demonstrated the usefulness of the TTM to identify an individual's current stage of change prior to ACP intervention and then following the discussion. The TTM assisted with initiation of ACP by the provider, and then guided the provider to assist in educating on ADs, if the situation found it necessary. Positive findings from this project implore the need for future ACP and AD education in the primary care setting, as many of the patient had forward movement in stage of readiness from pre-intervention to post. Patients were given information independent of what stage of readiness they were in, but

additional information should be available for providers and patients, in the form of brochures, pamphlets, print-outs, or other state-specific information, if patients should need it or request it.

Research

Findings from this EBP project lend additional information to the ever-growing body of evidence within the literature that supports methods to increase ACP and AD documentation. Findings may also be generalized to other healthcare facilities that include primary care or other specialty settings. The dissemination of the findings from this EBP project, through conference presentations and publication in academic journals will assist in educating and motivating providers to engage in ACP with their patients in their healthcare settings. However, despite the positive findings and impact of this EBP project, there needs to be additional research to identify continued challenges to ACP discussions in the outpatient settings and devise strategies to overcome them is needed. Gaps in the literature exist for younger adults, patients not presenting for a wellness or physical exam, specialty providers, individuals with cognitive health issues, or interventions that include patient education materials and the impact of timing of providing those materials. More investigation is necessary in order to adequately engage all potential patient populations in ACP.

Education

This EBP project has shown the necessity of education of not only the patients, but also the providers in implementing and initiating ACP in a healthcare setting. Using a formal educational session, providers and staff were given information on ACP and ADs, and all questions were answered. With that new or refreshed knowledge, providers were able to initiate ACP and discuss ADs with patients through the use of personal knowledge and pamphlets and paperwork provided by the state. APNs and nurses are known to be advocates for the furthering of knowledge for themselves and their patients, so taking in new knowledge and processing it to give to others is within their scopes of practice. APNs and nurses are the ideal candidates to educate their patients on ADs, because with this education, they are advancing their abilities to

be autonomous in their decision making, as well as allowing them to make decisions in regard to their end-of-life wishes while being well-informed of their options.

Conclusion

The purpose of this EBP project was to determine if the initiation of an ACP protocol based on the TTM stages of behavior change would increase ACP discussion rates and AD documentation within a primary care setting. The EBP project implementation was successful in increasing rates of ACP discussions, advancing patient's readiness for behavior change, and in AD completion and documentation rates. Results from this project are consistent with previously published literature and demonstrate the effectiveness of using an ACP protocol strategy to increase provider engagement in ACP with patients presenting for wellness or physical exams.

The DNP student was equipped with necessary knowledge and skills, as well as facility support, to be a change agent within the organization and incorporate a protocol to increase the ACP engagement of providers within the implementation setting. The Stetler EBP model provided the necessary guidance in researching and formulating a plan for project implementation, but the TTM provided the providers with the guidance and support necessary to initiate ACP discussions with the selected patients. The ACP protocol and TTM algorithm were accepted within the organization by the providers and leadership, which provided for easy implementation and support from additional staff. In addition, after speaking to leadership about the lack of ACP and AD support available to providers, EHR changes were made to facilitate provider documentation of ACP and ADs on each patient. Lessons learned from this, such as a facility to EHR support and consistent staff, will certainly prove useful for change in practice for future organizations or future researchers. Ultimately, this EBP project will continue to provide further support of ACP EBP implementations in the primary care setting, resulting in increased patient autonomy and support informed end-of-life decision-making through provider support of ADs.

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BIOGRAPHICAL MATERIAL

Ms. Engle graduated from Indiana University Northwest with a Bachelor of Science in Nursing in 2015. She has worked in a hospital intermediate care setting in various positions for the past eight years. Ms. Engle has been a member of her units shared governance team and is a mentor to both newly hired and graduated nurses. She has received specialized training and provided care for the treatment of cardiac, stroke, and bariatric patients over the course of her career. Ms. Engle has continued to provide care at the bedside while furthering her education in the Doctor of Nursing Practice (DNP) program at Valparaiso University. She is an active member of the Society of Nurses in Advanced Practice (SNAP) and American Academy of Nurse Practitioners (AANP). In 2018, she was inducted into Sigma Theta Tau, Zeta Epsilon Chapter. Ms. Engle has a passion for furthering the use of advance care planning after her clinical and work experiences have shown her how lacking knowledge is at every age and stage of health and illness. Her passion for advanced care planning has prompted her evidence-based practice project to educate and empower individuals on their choices prior to serious injury or illness. Ms. Engle also has a strong clinical interest in cardiac care and hopes to specialize in this area upon graduation.

ACRONYM LIST

ACP: Advance Care Planning

AD: Advance Directive

APN: Advance Practice Nurse

DNR: Do Not Resuscitate

CPR: Cardiopulmonary Resuscitation

CPT: Current Procedural Terminology

EBP: Evidence Based Practice

EHR: Electronic Health Record

ISDH: Indiana State Department of Health

IRB: Institutional Review Board

JB: Joanna Briggs Institute

MA: Medical Assistant

PICOT: population, intervention, control, outcome, time

POST: Physician Order for Life-Sustaining Treatment

PSDA: Patient Self-Determination Act

RCT: Randomized Control Trial

RN: Registered Nurse

SPSS: Statistical Package for the Social Sciences

TJC: The Joint Commission

TTM: Transtheoretical Model

APPENDICES**Appendix A***Advance Directive Education Pamphlet*

Indiana State Department of Health

2 North Meridian Street
Indianapolis, Indiana 46204

March 1999
Revised May 2004
Revised July 1, 2013

ADVANCE DIRECTIVES

YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a “physician”) about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer’s disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

“Advance directive” is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- ☐ Talking directly to your physician and family
- ☐ Organ and tissue donation
- ☐ Health care representative
- ☐ Living Will Declaration or Life-Prolonging Procedures Declaration
- ☐ Psychiatric advance directives
- ☐ Out of Hospital Do Not Resuscitate Declaration and Order
- ☐ Physician Orders for Scope of Treatment (POST)
- ☐ Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a "do not resuscitate" (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16.1. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A "health care representative" is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16-36-1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life - prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital, if you have a terminal condition and you do not want CPR, your physician will write a “do not resuscitate” order in your medical chart. If you are not in a hospital when an emergency occurs, the emergency medical personnel or the hospital where you are sent likely would not have a physician’s order to implement your directives. For situations outside of a hospital, the *Out of Hospital Do Not Resuscitate Declaration and Order* is used to state your wishes. The *Out of Hospital Do Not Resuscitate Declaration and Order* is found at Indiana Code § 16-36-5.

The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene your desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

A “Physician Orders for Scope of Treatment” (also referred to as a POST form) is a direct physician order for a person with at least one of the following:

1. An advanced chronic progressive illness.
2. An advanced chronic progressive frailty.
3. A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty there can be no recovery and death will occur from the condition within a short period without the provision of life prolonging procedures.
4. A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

In consultation with you or your legal representative, your physician will write orders that reflect your wishes with regards to cardiopulmonary resuscitation (CPR), medical interventions (comfort measures, limited additional interventions, or full treatment), antibiotics and artificially administered nutrition. You additionally have the option on the POST form to designate a “Health Care Representative” [see the section “Health Care Representative” above for additional information]. Note that if you have previously designated a health care representative and you name a different person on your POST form, the person designated on the POST form replaces (revokes) the person named in the previous health care representative advance directive. The Indiana POST form is available on the Indiana State Department of Health website at www.in.gov/isdh/25880.htm.

The POST form must be signed and dated by you (or your legal representative) and your physician to be valid. The original form is your personal property and you should keep it. Paper, facsimile (fax), or electronic copies of a valid POST form are as valid as the original. Your physician is required to keep a copy of your POST form in your medical record or; if the POST form is executed in a health facility, the facility must maintain a copy of the form in the medical record. The POST form may be used in any health care setting. The Physician Orders for Scope of Treatment statute is found at Indiana Code § 16-36-6.

Executed POST forms may be revoked at any time by any of the following:

1. A signed and dated writing by you or your legal representative.
2. Physical cancellation or destruction of the POST form by you or your legal representative.
3. Another individual at the direction of you or your legal representative.
4. An oral expression by you or your legal representative of intent to revoke the POST form.

The revocation is effective upon communication of the revocation to a health care provider.

POWER OF ATTORNEY

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

Several of the forms are specified by statute. Those forms may be found on the Indiana State Department of Health (ISDH) Advance Directives Resource Center at www.in.gov/isdh/25880.htm. The following forms are available on that web site:

- Living Will Declaration
- Life-Prolonging Procedures Declaration
- Out of Hospital Do Not Resuscitate Declaration and Order
- Physician Orders for Scope of Treatment (POST)

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

ADDITIONAL INFORMATION

For additional information on advance directives, visit the Indiana State Department of Health Advanced Directives Resource Center located at www.in.gov/isdh/25880.htm. The site includes links to state forms, this brochure, links to Indiana statutes, and links to other web sites.

The ISDH Web site contains a wealth of information about public health. Visit the ISDH Home Page at www.in.gov/isdh.

SUMMARY OF ADVANCE DIRECTIVES

- ☐ You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.
- ☐ Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.
- ☐ No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.
- ☐ This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
<http://www.in.gov/isdh>

APPENDIX B*Introductory Letter for Patients on ACP Protocol*

Dear Patient,

We would like to inform you that you have been selected to take part in an evidence based practice project here in our office. Christine Engle BSN, RN is a Doctor of Nursing Practice student at Valparaiso University and is conducting this project as part of her coursework to fulfill her doctoral degree. This quality improvement project will focus on advance care planning for adult patients who are scheduled with our family nurse practitioners. If you are receiving this letter, you meet the criteria and are eligible to take part in this project.

Keep in mind that at no time during this project will you be required to have or develop an advance directive. This project has been designed to simply inform patients of their choices for advance care planning, choices about end-of-life wishes that are best made when patients are not hospitalized or critically ill.

Along with this letter you are receiving an advance directive information booklet, commonly asked questions about advance directives, and Indiana forms for Health Care Representative and Living Will Declaration. Please take the time to review these forms prior to meeting with your health care provider. The health care provider will ask you just a few questions based on whether or not you currently have an advanced directive, and answer any questions you may have at that time. You may choose not to engage in the advance care planning discussion at any time.

If you agree, you may be contacted following the appointment to answer any additional questions and follow-up on the advance care planning discussion.

Your time is greatly appreciated in the completion of this quality improvement project.

Sincerely,

Christine Engle BSN, RN

Doctor of Nursing Practice candidate

APPENDIX C*Patient Most Frequently Asked Questions Hand-out***Q: What are advance health care directives?**

A: Advance health care directives are written instructions to your loved ones and others about the type of medical treatment and health care you would like to receive if you're unable to communicate directly with your health care providers.

Q: What is a living will?

A: A living will is a legal document that puts into words your wishes for medical treatment if you are very ill or unable to communicate or talk. A living will includes specific care or treatment you WANT or DO NOT want during a serious illness.

Under a living will, you can state whether you want - or don't want - certain life-sustaining or life-saving procedures, including artificial respiration, cardiopulmonary resuscitation or CPR, and artificial means of providing nutrition and hydration.

Q: What is artificial nutrition, hydration, and respiration?

A: Artificial nutrition and hydration refers to the use of other means to feed and hydrate a person who is not able to eat and drink on their own. It usually includes giving food and/or water through an intravenous catheter (called an "IV") or through a nasogastric (nose) tube.

Artificial respiration means that you are not able to breathe on your own, and may require the use of a machine or tube to breathe for you, commonly called a ventilator.

Q: What is a healthcare representative?

A: A "healthcare representative" is someone you choose to receive your health care information and make health care decisions for you when you cannot. You can also include instructions about the types of medical treatments you want or don't want.

Whoever you decide to name as your representative should be someone you know very well. It should be someone you respect and someone whose judgment you value. This person should also have a good understanding of who you are and what your values and feelings are.

Q: At what age should I complete a healthcare proxy and a living will?

A: Any person 18 years or older should have a completed healthcare representative and living will, outlining their healthcare wishes. This is not only for older adults whose health may be declining. Unfortunately, accidents happen at any age and these forms communicate your wishes to health professionals.

Q: Where should I store these documents?

A: You should keep the originals in a safe place, particularly one that is free of any potential water or fire damage. It is also a good idea to give copies of these documents to the people who are most likely to need this information, such as your healthcare provider, attorney, and those named as healthcare representatives. It is also important to make sure that your advance directives are part of your permanent medical chart.

Q: How long will my advance directives last?

A: There is no time limit for these documents. Generally, they will last until you change them or cancel them. You may change or cancel them at any time by simply signing new documents or canceling current ones. It is always a good idea to destroy your old documents so that they aren't confused with your new ones.

Q: Must a lawyer create my advance directives?

A: **No.** Your health care representative and living will declaration can be completed by yourself and signed by two witnesses. These forms are valid and binding.

APPENDIX D*Patient Consent Form***Valparaiso University**

Consent Form for Participation

Dear patient,

I am a student at Valparaiso University in the doctorate of nursing program. I am conducting a quality improvement project, which I invite you to take part in. The purpose of this project is to increase advance care planning and advance directive documentation in adults, when they are not seriously ill or hospitalized. Possible benefits to you will include education on the topic and the opportunity to ask any questions to experienced health care providers.

If you agree, you may be contacted by phone following your appointment with your primary care provider. I, Christine, the project leader, will personally call you, to ask if you have any further questions following the advance care planning discussion, and if you have filled out any additional advance directive documents after the visit. None of your personal information will leave the clinic site, Northshore Health in Chesterton.

Participation is voluntary and you may choose not to be a part of this project at any time. By signing below, you are giving the project leader permission to contact you following your scheduled appointment.

Participant's name (printed)

Participant's signature

Date

APPENDIX E

Advance Directive Forms



INDIANA LIVING WILL DECLARATION

State Form 55316 (5-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIVING WILL DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease, or illness;
- (2) my death will occur within a short time; and
- (3) the use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration.

(Indicate your choice by initialing or making your mark before signing this declaration.):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date (month, day, year) _____

Witness _____ Date (month, day, year) _____


INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)

Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday (mm/dd/yyyy)	Medical Record Number of Healthcare Facility or Provider (optional)	Healthcare Facility or Provider (optional)
Appointment of Health Care Representative		
<p>I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).</p> <p>I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.</p> <p>I specify the following terms and conditions (if any):</p>		
Name of Representative Appointed	Address of Representative (number and street, city, state, and ZIP code)	Telephone Number of Representative
Signature of Patient / Appointor or Designee (must be signed in the appointor's presence)	Printed Name of Patient / Appointor or Designee	Date of Appointment (mm/dd/yyyy)
Signature of Witness	Printed Name of Witness	Date (mm/dd/yyyy)

INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.
2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.
3. An individual is not required to complete a health care representative appointment form. An individual may always choose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.
4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.
5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.
6. The authority granted becomes effective according to the terms of the appointment.
7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.
8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.
9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.
10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
 - a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
 - b. In good faith.
11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
 - a. The patient / appointor.
 - b. The patient's / appointor's legal representative if one is known.
 - c. The health care provider if the representative knows there is one.
12. An individual who is capable of consenting to health care may revoke:
 - a. The appointment at any time by notifying the representative orally or in writing; or
 - b. The authority granted to the representative by notifying the health care provider orally or in writing.

APPENDIX F

*Advance Care Planning Algorithm***FOR OFFICE USE**

Patient refused ACP discussion _____

Advance Care Planning ProtocolDate:Provider: Gavin NicholsAge:Gender:Race:Marital Status: Married Single Divorced/Separated WidowedChronic Diseases (Circle all that apply):

HTN

DM

COPD

CAD

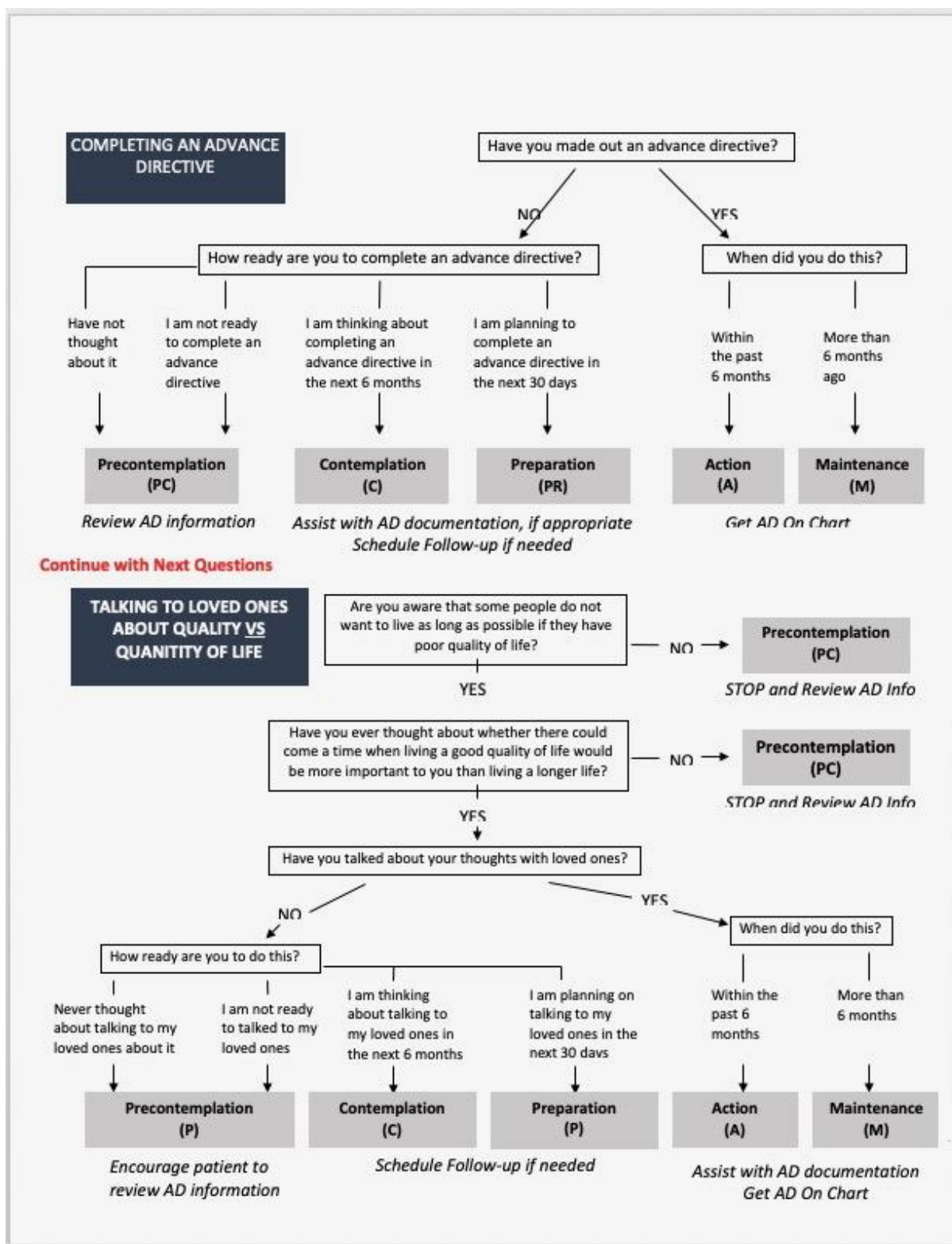
Heart Failure

Cancer

Stroke

Other: _____

AD filled out: YES NOAD documented in chart: YES NO



APPENDIX G

Power Point Presentation:

Implementation of an ACP Protocol in Primary Care

IMPLEMENTATION OF ADVANCE CARE PLANNING IN PRIMARY CARE

Christine Engle BSN, RN
Valparaiso University
College of Nursing and Health Professions

SIGNIFICANCE

- Most of the adult population does not consider advance care planning (ACP) until it is critically needed or illness occurs
- Many will undergo futile or inappropriate interventions at end-of-life because they did not have the opportunity to make their wishes known
- Lack of ACP prior to health crisis may have the potential for not only increased financial costs, but also personal costs, such as utilization of unwanted invasive treatments, lack of autonomy, decreased quality of life, increased stress and anxiety on loved ones, and increased moral distress on health professionals
- Evidence shows that patients may prefer initiation of ACP within the outpatient setting with their primary care providers
- Completion rates remain low despite the many benefits of advance care planning

SUGGESTED ACTION

- Primary care providers are an ideal candidate to begin ACP with their patients because of established trust and long-term relationships
- It is suggested that ACP begin and end-of-life wishes are discussed when the patient is still of sound mind and body and able to ask questions and make their own healthcare decisions
- Beginning this conversation during the patients scheduled wellness visits will allow for increased patient autonomy and knowledge of their end-of-life choices

BARRIERS TO ACP

- Barriers to initiating ACP in the office setting have been identified for both patients and the providers
 - **Provider barriers:**
 - Lack-of-time during appointments
 - Assumptions that patients will bring up the topic
 - Perception that patients do not find ACP important or necessary
 - Belief that patients may not understand difficult terminology
 - Lack of reimbursement
 - Discomfort with the topic
 - Lack of dispensable information or system support
 - **Patient barriers:**
 - Expecting the provider to begin the conversation
 - Belief that they are "too young" or "too healthy"
 - Lack of Knowledge on advance directives (ADs)
 - Discomfort with the topic

TARGET ORGANIZATION BARRIERS

- Practice focuses on high quality, time- effective care
 - ACP needs to be fit into appointments
- Currently no allotted time for ACP discussions in office visits
- No readily available information or education for patients in regards to ADs

AD TERMS

- ADs refer to spoken and written instructions about future medical care and treatment for use when an individual is incapacitated
- ADs are specific instructions on the patients wishes and values for end-of life care
- Indiana recognizes eight specific ADs
 - Direct conversation with family and providers
 - Organ and tissue donation
 - Health care representatives
 - Living Will Declaration or Life-prolonging Procedures Declaration
 - Psychiatric advance directives
 - Out of hospital Do Not Resuscitate Declaration and Order
 - Physician Orders for Scope of Treatment (POST)
 - Power of attorney
- Most commonly utilized are Living Will Declarations and Health care representatives

LIVING WILL

- A living will is written documentation of an individual's wishes in the event they become terminally ill or unable to communicate
- Lists specific care or treatment that is wanted or not wanted
- Often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions
- Living Will declaration informs providers and families that life-prolonging treatments should not be used so that natural death is allowed to occur
 - Not all life-prolonging treatments need to be prohibited, such as artificial nutrition and hydration
 - May also specify that someone else will be allowed to make the decision

Indiana State Department of Health, 2013

HEALTHCARE REPRESENTATIVE

- A person who is chosen to receive health care information and make health care decisions when an individual is unable
- Chosen individual may agree to or refuse medical care and treatments based on an individual's advance directive
 - May choose if artificial nutrition or respiration should be given as part of medical treatment

Indiana State Department of Health, 2013

FORMS

- For providers:
 - Algorithm worksheet
 - Patient consent for future contact following appointment
- For patients:
 - Intro letter
 - ISDH Advance Directive brochure
 - Frequently Asked AD Questions
 - Living Will Declaration and Health Care Representative forms

CLARITY OF ROLES

- **Front Desk:** Provide blue folder to all patients 50 years and older presenting for a wellness exam or physical. Inform to look over information while waiting to meet with provider.
- **Nursing:** When taking patient back to room, ensure that they have a blue AD folder. Fill out demographic portion of algorithm worksheet (yellow paper) and place at computer for provider. If patient refuses conversation, mark on sheet and place in designated folder.
- **Healthcare Provider:** Follow AD algorithm/protocol, circling patient responses and intervention. If an AD is drafted, scan into medical records and document on algorithm worksheet. If indicated, advise patient to schedule follow-up appointment. Place algorithm worksheet into designated folder.

Questions?